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The Effects of Gender and Race on Physician Treatment of Patient Emotion.

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THE EFFECTS OF GENDER AND RACE ON PHYSICIAN TREATMENT OF PATIENT EMOTION

A Dissertation

Submitted to the Faculty of the
Louisiana State University and
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in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The Department of Sociology

by
Vaughn A. DeCoster
B.A., University of Arkansas, 1990
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Dedicated
to the memory of
Fr. Carleton Anselm Sheehan, O.S.B.,
for your limitless encouragement
and unfaltering belief in my scholarly abilities.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

This study established theoretical and empirical foundations for the investigation into how physicians deal with (treat) patient emotion. The questions posed, "Do physicians employ specific strategies to treat patient emotion?" and "What are the effects of physician-patient social characteristics (gender and race) on emotion treatment?" Coalescing two seemingly incongruent perspectives (social constructionism and Kemper's social relational theory), I clarified the conceptual basis for the emotion management of other people. From these perspectives, I developed a three stage theory to describe and explain the physician treatment of patient emotion (triaging, diagnosing, and treatment), as well as appreciate the effects of social characteristics on this process.

Regarding the first research question, survey data collected from 225 practicing physicians supported the twenty-two proposed strategies to treat patient emotion. Considering the second question, analyses produced some support for the predicted effects of gender and race. For physician gender, female physicians were, in general, more likely to treat patient emotion than their male colleagues. However, physician gender was only significant when the physicians' type of medical practice (general vs. specialized) and practice setting (private vs. institutional) were controlled in the analysis model, suggesting that physician gender differences were more complex than those based exclusively on sex. For patient gender and race, analysis indicated that physicians randomly assigned black patient vignettes had significantly higher scores on measures of *emotion evading* and lower scores for *emotion importance* than physicians

with white patients. This suggests that a patient's social characteristics do influence physician treatment of patient emotion. Overall, my research demonstrates a growing ideological acceptance and consideration for the role of emotion in medicine, whether this is occurring in actual practice remains unknown.

CHAPTER I:

INTRODUCTION

In the practice of medicine, patient emotions are both frequent and important. It is easy to imagine, or possibly recall from actual experience, the fear felt during an acute physical injury or illness, the anger of being diagnosed with a chronic disease, or simply the anxiety of a routine medical examination. These are medical situations in which emotions are indeed present in some form or another. Furthermore, physicians are often the first health care professionals patients contact regarding emotional problems, such as emotionally laden personal, familial, or social problems.

The importance of patient emotion in medical care can be attributed to several trends: a growing popular association of emotional wellness and health, an increasing appreciation of the holistic nature of human beings, medicine's trend toward a bio-psycho-social paradigm, and recent linkages of emotion to various medical communication processes and treatment outcomes. However, despite the frequency and suggested meaningfulness of emotions in health care, rarely are the strategies physicians use to assist patients with their emotions addressed by physicians themselves, medical schools and residency programs, or social/behavioral science researchers informing them (More and Milligan 1994).

In this dissertation I addressed two general questions regarding the strategies physicians use to manage (treat) patient emotions. First, do physicians employ specific strategies to treat patient expressed emotions? In answering this question, I intended to

show that physicians utilize a number of identifiable and distinct methods to treat patient emotions during physician-patient interactions. The second question I asked, do social characteristics of physicians and/or patients affect the probability or form of emotion treatment? In this facet of my study, I explored physician and patient social structure characteristics as important determinates for a physician's probability and selection of strategies to manage patient emotion during out-patient interactions.

Our knowledge of how physicians treat patient emotions and what influence, if any, physician and patient social structure characteristics have on this dimension of their interactions is limited and somewhat dated. This study filled a gap in the literature by systematically examining the strategies physicians use to treat patient emotion and the extent to which specific social structure characteristics affected this process. In doing so, my study contributed to sociological theory on emotion in two ways, content and process. Content refers to the basic terms that describe and explain the elements of emotion management. Process is the underlying sociological impetus which explains how the content is applied.

Two advances were made regarding theoretical content. First, I clarified and extended social constructionism's emotion management theory. Specifically, emotion work and emotion labor are two integral concepts in emotion management theory, originally defined as the shaping and controlling of an *individual's own* emotion experience, often referred to as self emotion management. *Emotion work* is self emotion management done in private life (interactions with family and friends) to fit prevailing cultural norms relevant to the present situation. *Emotion labor* is self

emotion management performed for paid employment (interactions with customers, clients, or patients). Building upon these, I introduced two concepts that focus on our efforts to manage the emotion of *other people*: emotion directing and emotion treatment. *Emotion directing* is the shaping and controlling of the emotion experience of other people (others), done in our private lives. *Emotion treatment* is defined as the shaping and controlling of another person's emotion experience as part of a professional health care role (e.g. clinical social worker, nurse, physician, or psychologist).

Second, this expanded theory of emotion management was utilized as the framework for examining physician treatment strategies (methods, practices) for patient-expressed emotions. Relying on previous work in this area which typologized and operationalized physician emotion treatment strategies, I developed an instrument to measure the emotion treatment practices of physicians, in effect testing the validity of the strategies.

Regarding process, I proposed a theoretical framework to explain physician treatment of patient emotion. Physician emotion treatment was conceived as a three step procedure, rather than a single behavioral event. First, physicians prioritize patients in an effort to ration their own commodities of time and energy: *patient triaging*. Second, they determine the presenting emotion: *emotion diagnosis*. Third, physicians choose appropriate techniques to treat a patient's emotion: *strategy selection*. The underlying forces for this process are two social elements: power and status. With power and status concepts I developed a sociological explanation, based predominately

on Theodore Kemper's (1978, 1987, 1990) social relational approach to emotion, for physician treatment of patient emotion.

In addition to advancing our understanding of physician treatment of patient emotion, my instrumentation and empirical findings have applied value. Operationalized emotion treatment strategies can actually be used, experimentally manipulated, and then examined for their effectiveness across different patient populations, institutional settings, as well as across various types of emotion. Empirical findings denoting the influence of an individual's power and status characteristics on physician treatment of patient emotion could prompt a closer examination of these and other social factors on the delivery of health care, especially in the education and training of medical students or any health care professionals requiring direct therapeutic interactions with patient populations. In a similar vein, these findings would be beneficial for the continuing education of practicing physicians and other health care professionals to enhance emotion treatment skills, cultivate more congenial "bedside manners," decrease discriminatory emotion treatment practices, and increase related positive outcomes. [1] In general, this research provides baseline data and

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[1] As Frankel (1995) notes, "some insurance companies are even offering reductions in malpractice premiums for physicians who either possess or agree to learn better communication skills" and that even the A.M.A. has recognized that one of the best preventive measures for litigations is a good patient-physician relationship (p. 170). Likewise, a large health care provider, employing over one hundred physicians, recently initiated in-service training on effective doctor-patient communications, aimed at reducing rates of litigation by keeping patients happy.

methods to establish more unbiased and effective management strategies for patient emotions, who in turn could benefit in a number of ways, discussed later in this chapter.

Before proceeding further, I now outline the chapters for this dissertation. I consider pertinent literature, in Chapter I, detailing the importance of emotion in health care as well as the trends in physician treatment of patient emotion in outpatient consultations. Chapter II outlines the present state of the sociology of emotion and specifies my own theoretical preferences. Within this second chapter I discuss the effects of two social structure elements on popular as well as physician emotion cultures, speculating whether these potential differences are cultural, structural, or both. Then I argue that two seemingly incongruent perspectives in the sociology of emotion are complimentary and useful in explaining physician-patient interaction. Put simply, I use social constructionism to describe the *content* and structuralism (social relational theory) to explain the underlying *process* of physician treatment of patient emotion. I then apply this theory to the above research questions, defining and operationalizing the specific concepts and variables. Chapter III delineates the research and data analysis methodologies for this study. Chapter IV presents and describes my empirical findings. Finally, Chapter V summarizes and discusses these results and possible directions for future research in the sociology of emotion.

Emotion and Medicine

Emotion's Presence in Medicine

According to physician William Zinn,"The medical encounter, like all human interaction, is unavoidably emotion laden" (1988, p. 3296). This tenet that medicine is

"emotionally laden" has growing acceptance among social scientists as well (Bowman and Gehlbach 1980; DeCoster 1997; Locke 1996; More and Milligan 1994; Ong et al. 1995). In these "emotionally laden" medical encounters physicians witness a variety of patient emotions - fear, anxiety, sadness, depression, and occasionally anger (Baker, Yoels, and Clair 1996). These emotions can be responses to physical injury or illness, the treatment itself, or characteristics of an underlying psychopathology (Bowman and Gehlbach 1980; Eisenberg 1993).

In addition, physicians are often the first health care professionals patients contact regarding emotionally laden personal, familial, or social problems (Bish et al. 1996; More and Milligan 1994). For primary care physicians alone, approximately thirty percent of problems patients present are psychosocial in nature (Bertakis, Roter, and Putnam 1991; Cassata and Kirkman-Liff 1981; Eisenberg 1993). Likewise, as many as eighty-five percent of primary care patients show a degree of psychological (emotional) distress (Starfield et al. 1981). Despite the mere presence of patient emotion, why should physicians or researchers be concerned with it in the practice of medicine?

The Importance of Emotion in Health Care

In general, there is increasing evidence from the behavioral sciences, as well as an increasing popularity within the general public, of an association between emotion and health (American Psychiatric Association 1994; Cousins 1990; Freund and McGuire 1995; Goldberg 1991; Johnson 1990). Specifically, scientists purport a number of emotion-health connections, for example the linkage of suppressed anger

with hypertension and cancer (Eysenck 1988; Harburg et al. 1973; Pickering et al. 1991; Temoshok 1990), depression's compromising effect on the immunological system (Stone et al. 1987), as well as the multiple consequences of stress/anxiety on general health (Greenberg 1993). With this evidence in mind, it is reasonable to assume that some form of emotion-health linkage exists.

Considering physicians are often the initial professional contacted regarding emotion (Bish et al. 1996; More and Milligan 1994), what effects, if any, are there for physician interventions with patient emotion in the medical consultation? Appraising the emotion component of medicine in general, Rutter et al. (1996) suggest that physicians, in this regard, have great opportunities to generate some positive effects on the health of patients. However, attempts at answering this question focus on indirect (e.g. benefits to communication, satisfaction levels, continuity of care) rather than direct effects on patients health (e.g. improved mental or physical health).

Physician treatment of patient emotion enhances doctor-patient communication.[2] Physicians with a greater appreciation for the emotional aspects of health care obtain more comprehensive and valid medical information from their patients (Fisher 1995; More and Milligan 1994; Stiles et al. 1979). In addition, physicians utilizing an empathically oriented communication approach are, in general, asked more questions by their patients as well as more appropriate problem-related questions (Roter 1984).[3]

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[2] For a comprehensive review of doctor-patient communication research see Ong et al. (1995).

[3] Empathy, as related to physicians, is defined as the capacity to take in and

(continued...)

Physician treatment of emotion enhances patient satisfaction. Physician recognition of the emotional aspect of a patient's health is an essential element in patient satisfaction with both the provider and corresponding institution (Bertakis, Roter, and Putnam 1991; DiMatteo, Hays, and Prince 1986; DiMatteo et al. 1980; Street and Buller 1987; Wasserman et al. 1984; Wilson et al. 1995).[4] In contrast, physician insensitivity toward patient emotion leads to dissatisfaction (Goleman 1991). Importantly, adequate patient satisfaction is associated with greater confidence in the physician, higher rates of compliance with the treatment plan, and decreases in the likelihood that patients will switch physicians (Frankel 1995; Hall, Roter, and Katz 1988; Lo et al. 1994; Milmoe et al. 1967; Roter and Hall 1993), a practice commonly called "doctor shopping."

Physicians' emotion treatment skills and strategies have financial and legal implications for both individual practitioners and larger health care systems. Health care is a multi-billion dollar industry with both providers and institutions competing for patients in what is described as a true "buyers' market" (Goldsmith 1981). Today's medical patients, now often referred to as "consumers", are more empowered to make decisions, better informed about health care, yet frequently judging the quality of their medical care on the interpersonal interactions with the physician (Hall, Roter, and Katz

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[3](...continued)
appreciate the emotional life of another while maintaining a sufficient sense of self to permit cognitive structuring of that experience (More and Milligan 1994). According to Buchsbaum, "Empathy conveys caring, the *sine que non* of the doctor-patient relationship" (1986, p.425).

[4] In addition to patient satisfaction, physician job satisfaction is significantly higher when both practitioner and patient emotion, described as being inherent in the practice of medicine, are directly addressed (Roter and Hall 1993; Shapiro 1988).

1988). If patients "feel" unsatisfied with their care, despite its technical quality, they are more likely to change providers (Todd 1989). Likewise, as many hospital risk management directors know, happy patients are less litigious toward either the institution or individual practitioner (Beckman et al. 1994; Lester and Smith 1993; Messenger 1989; Volk 1992).

Considering the above, it is reasonable to assert that emotion plays a consequential role in medicine for patients, providers, as well as institutions. Although a more complete investigation into these effects is certainly merited, the logical starting point is an exploration of the strategies physicians use to treat patient emotions.

Trends in Physician Treatment of Patient Emotions

Traditionally, medical practitioners' have sought to "sterilize" the medical milieu of emotion, parcel it out and leave it for the "touchy-feely" professionals (e.g. clinical social workers, psychiatrists, or psychologists). In other words, physicians viewed emotions as obstacles to the practice of medicine and simply tried to avoid them (Good 1994; Smith and Kleinman 1989). Western medicine's cultural norm to circumvent patient emotion was supported by its long held advocacy for the scientific-practitioner model: an objective, analytical, and non-emotional approach to the practice of medicine and the patient-physician relationship (More and Milligan 1994; Roter and Hall 1993; Todd 1989). To achieve this goal of emotionally "sterilizing" the patient, physicians typically relied on humor/laughter, medication, mental health referrals, or ignoring the patient's emotion altogether (More and Milligan 1994; Smith and Kleinman 1989). Nevertheless, as the literature on the influence of emotion suggests,

the attitudes and beliefs about the role of emotion are changing in contemporary medicine, yet how these changes translate into actual practice is still undetermined.

The majority of research considering physician treatment of patient emotion does so rather circuitously, often exploring rather vague socio-emotional interaction and/or communication styles of the physician. These ubiquitous approaches for dealing with patient emotions have several variations: affective regard (Klingle and Burgoon 1995), affiliativeness (Street and Buller 1987), reassurance (Buchsbaum 1986), and sympathy/empathy (DiMatteo, Hays, and Prince 1986; Fine and Therrien 1977; Harrigan et al. 1989; Morantz-Sanchez 1985; More and Milligan 1994; Roter and Hall 1993; Rosenberg and Towers 1986; Spiro 1993; Suchman and Mathews 1988; Wasserman et al. 1984). Regarding the latter, researchers typically view empathy as the physician's ability to identify with or feel for (sympathize) his or her patients. Again, the focus here is on a physician's basic *socio-emotional style* of interacting and/or communicating with patients across all components involved in the practice of medicine (educating about medications, explaining a procedure, performing a physical exam, etc.), not on particular emotions nor definitive techniques physicians use to specifically treat patient emotions.

Other researchers explored various strategies and approaches for dealing with certain "emotionally laden" situations: initial socialization of medical students (Smith and Kleinman 1989), hateful patients (Groves 1978), patients diagnosed with Human Immunodeficiency Virus (Coates and Lo 1990), grieving families (Fuller and Geis 1985), or the negative emotions of pediatric patients and their families (Locke 1996).

This cluster of literature is closely related to the present study, how physicians specifically treat patient emotions and warrants closer review.

Smith and Kleinman (1989) use participant observation to study medical school students' emotion management strategies for coping with the feelings associated with medical training and clerkships. As the authors report, medicine's unwritten goal for this socialization process is the students' achievement of affective neutrality. According to Smith and Kleinman, to achieve this goal students use six strategies: "transforming the patient or procedure into an analytic object or event, accentuating the comfortable feelings that come from learning and practicing 'real medicine,' blaming patients, empathizing with patients, joking, and avoiding sensitive contact" (p. 57). Although their study focused on the student's control of their *own* emotions, the authors did briefly suggest that some of these methods are also used to manage the emotion of patients. Qualitative data were collected, yet no analysis beyond simple descriptions was offered and no particular theory was advanced. In addition, this study is unclear whether these strategies persist in post-graduate practice.

In one of the earliest direct attempts to address the treatment of patient emotion in the practice of medicine, Groves (1978) offered a psychoanalytical approach for physicians to identify and deal with four types of "hateful patients" (dependent clingers, entitled demanders, manipulative help-rejecters, and self-destructive deniers) to create a more effective medical care milieu (i.e. one which is less emotional or, as stated earlier, "emotionally sterile"). Hate is the physicians' own counter-transference response to the *dependent clinger's* emotional neediness, *entitled demander's* hostility, *manipulative*

help-rejector's pessimistic neediness, and the *self-destructive denier's* lack of emotional seriousness. Proposed methods for dealing with these patients approach the relationship as a whole, not the specific patient emotion. For the dependent clinger Groves recommends establishing clear relationship boundaries, for the entitled demanders - acceptance and rechanneling of their energies, for manipulative help-rejecters - empathy and "gentle reasoning," and for a self-destructive denier - encouragement and support. In general, the article identifies patient personality types and their mood traits, rather than distinct emotions.[5] Although this study has a theoretical base, albeit modest, it lacks empirical data to support its emotion treatment recommendations and fails to show whether these theoretical strategies differ significantly from existing practices.

Coates and Lo (1990) considered the emotions facing medical patients diagnosed with Human Immunodeficiency Virus (HIV) and offered strategies based on the crisis counseling model. At the onset, Coates and Lo asserted the need for health care providers to "allow patients to express their feelings, reactions, and concerns; and convey concern for the patients' emotional state" (p. 629). The authors contemplated a number of emotions and emotionally endowed issues (uncertainty/anxiety, anger, betrayal, denial, fear, regret, and depression). Coinciding with these, they suggested several physician strategies, most of which could have been categorized as recognizing and accepting patient emotion, nonjudgmental listening, empathic statements,

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[5] As Smith-Lovin (1995) indicates, moods are persistent patterns of individual feeling which are transitional in nature, in essence we carry a particular mood from situation to situation, and relatively unspecific. In contrast, emotions are temporally short-lived, specific, and tied to the immediate situation.

encouraging expression, inquiring about the emotion and its related factors, offering reassurance, and referral to appropriate agencies. Unfortunately, this work did not collect empirical data and was based solely on conjecture.

Similarly, Fuller and Geis (1985) recommend methods for dealing with grieving family members. They assert that the physician is in an ideal position to assist the families of terminally ill patients with grief and other emotionally related issues by facilitating communication. "Interview techniques" are proposed for five areas: (1) social unacceptability of presenting symptoms and death itself; (2) helplessness, anger, and guilt; (3) sexual feelings and expectations; (4) specific preparation for death; and (5) bereavement and grief after death. Inasmuch as physicians are encouraged to acknowledge, accept, and clarify patient feelings, the authors actually offer only two distinct strategies, either initiate a conversation in the area of concern or refer-out to other resources (e.g. professionals, agencies, various information sources). As with the previous work, this piece lacked both empirical data and a conspicuous theoretical basis.

Using qualitative methods, Karen Locke (1996) described pediatricians' "comedic performances" to manage the negative emotions of patients and families. From observational, interview, and archival data collected in the pediatric department of a tertiary care hospital, she identifies four comedic strategies (sociability, mastery, ostentatious celebratory, and magical performances), with the intentions for "display and generation of fun: incompatible with the anxiety, fear, and despondence patient families typically bring to medical encounters (p. 40)." The author avoided three inadequacies of previous works. First, Locke concentrated on how physicians deal

with (treats) patient/family emotion, not the physician's own emotion. Second, this study was based on empirical data, not merely conjecture. Third, a theoretical framework, albeit rather discombobulated, was offered to explain the strategies. However, as the author pointed out, this study concentrated only on comedic-playful strategies, is unlikely to be generalizable beyond pediatric medicine, and is based on a single department consisting of only nineteen male physicians in a tertiary (specialized not general) care institution.

As the above literature illustrates, most work in this area of emotion and medicine focuses on a physician's usual socio-emotional style of interacting or communicating with patients. There is little research exploring emotion specifically and those that do have several problems. First, many of these works are pure conjecture. Second, most lack a theoretically guided systematic approach. Third, few of the studies collect empirical data to substantiate their claims. Fourth, only one study delineates existing physician strategies. As I demonstrate in the next chapter, the sociological perspective offers an excellent framework to address these deficits in the examination of physician treatment of patient emotions.

CHAPTER II:

THE SOCIOLOGY OF EMOTION

Although in the past emotion was occasionally addressed in sociology, even within classic sociological works (see Smith-Lovin 1995 for a review), it has only been since the mid-1970s that emotion became an acceptable focus of theoretical and empirical study. Since this time, a substantial amount of work in the sociology of emotion demonstrates its progress and success within the discipline (see Smith-Lovin 1995 or Thoits 1989 for a review). However, as suggested by Kemper (1990) and Smith-Lovin (1995), this field's development has been hampered by three shortcomings. First, we lack theory which explains the underlying process of emotion as well as its management. Second, researchers have gathered little empirical data from people outside the traditional undergraduate subject pool. And third, few studies have had clear and identifiable applications in the "real world." My study of physician treatment of patient emotion attempts to address these deficits.

In this dissertation, I develop a fundamental theory of emotion management by coalescing and applying two seemingly incongruent perspectives found within the sociology of emotion (constructionism and structuralism), the first deficit. Within these theories I construct an instrument to measure physician management of patient emotion which contains practical examples of treatment strategies, the third deficit. I then use this instrument to collect empirical data from practicing physicians, the second deficit.

My theoretical position for this study is presented in two segments. In the first segment I draw on the constructionist perspective to describe the *content* of physician

emotion treatment. In this regard I will discuss fundamental assumptions, concepts, and specific emotion management strategies. In segment two, I evoke the structuralist perspective to explain the *process* of this physician emotion treatment, i.e. the underlying social patterning of emotion management behaviors associated with interactants' social structure characteristics.

What is Emotion?

The social constructionist perspective, most clearly illustrated in the works of Averill (1980), Clark (1990), Gordon (1981, 1989, 1990), Hochschild (1979, 1983, 1990), Shott (1979), and Thoits (1989, 1990, 1991, 1996), asserts that of all the possible processes which shape and control our emotion experiences and expressions (i.e. biological, psychological, or sociological) it is the sociological (socio-cultural) that takes precedence. I rely on this perspective to define the *content* of emotion and emotion management.

The concept of emotion advanced in this study was based on Thoits's four factor model of emotion (1984). She defines *emotion* as an experience comprised of four components: *situational cues* (definitions of the situation), *physiological cues* (internal biological changes in arousal), *behavioral gestures* (observable expressions), and *cognitive labels* (specific names/labels) applied to the configuration of each unique set of components tying them together. These "feeling components" are socially learned, repeatedly reinforced in interactions, and interdependent. In essence, modifying one component will influence the others and have the potential to alter the experienced emotion as a whole. However, an emotion can be experienced without all four of its

components, such as being afraid without knowing the reason why (Smith-Lovin 1995). This multi-component definition of emotion was indispensable in my conceptualization of emotion management, discussed later in this chapter.

The Potential for Control: People as Sentient Beings

Another essential assumption in the social constructionist approach is that as feeling individuals we are *sentient beings*, in other words, actively reflecting on and regulating emotion. This differs from many psychological and some sociological theories of emotion which take a socio-biological positivist perspective, considering emotion as an automatic or spontaneous innate natural response (Buck 1984; Carlson and Hatfield 1992; Kemper and Collins 1990; Kemper 1978, 1987, 1990). The concept of sentience, as applied here, is not to deny the role of biology in emotion, rather it asserts that even the physiological components are often personally managed, professionally treated, and in many cases today psycho-pharmacologically manipulated, all according to salient cultural norms applied within structural frameworks.

Sentient beings have the ability to manipulate and contort (manage) both experienced and expressed emotions. I assert, as many sociologists studying emotion do, that socially constructed culture provides the potential *content* we as sentient beings draw from for emotion experiences, expressions, and management. However, this content manifests itself according to an underlying fundamental structural *process*, as I will explain in a subsequent section.

Informing Sentient Beings: Emotion Culture

According to Gordon (1990), *emotion cultures* are composed of emotion vocabularies (words describing and labeling emotions), emotion expression/feeling norms and rules, and general beliefs/attitudes about these emotions. As Gordon suggests, geographic regions, sub-cultures, various social groups, and even professional groups can have unique emotion sub-cultures. If this is correct, what is the emotion culture for physicians?

As the literature reviewed in chapter one suggests, the traditional emotion culture in medicine was one which discouraged emotion both in practitioners and patients, favoring an objective emotionally sterile scientific milieu. This position is falling out of favor in today's health care milieu. Contemporary trends in the general public and medical cultures denote an increasing recognition and appreciation for emotion in health as well as in the practice of medicine. Whether this translates into changes for physician practice norms remains an empirical question. Also lacking an empirically informed answer is the question, do common social structure elements influence the general public and/or physician emotion cultures?

Social structure affects many dimensions of our social lives (House 1995). For example, sociologists have demonstrated social structural influences on personality (House 1981), small group processes (Balkwell 1994), socialization (Inkeles 1968), social exchange (Blau 1964), as well as emotion and its related elements (Kemper 1990; Smith-Lovin 1995).

Gender and race are two of the most significant parameters of social structure, which in turn have remarkable influences on the individual residing therein (House and Mortimer 1990). Judith Lorber envisions gender's far reaching effects as "an institution that structures every aspect of our lives because of its embeddedness in the family, the workplace, and the state, as well as in sexuality, language, and culture" (1994, p. 5). Omi and Winhant describe the magnitude of race's expansive influence as "a fundamental role in structuring and representing the social world" (1994, p. 55). Taken together, these two social structural characteristics shape and influence a great deal of human social life (Grusky 1994). Hence, it would be of interest to examine how gender and race as structural elements affect the general public and physician emotion cultures, in particular how these two factors operate with regard to physician treatment of patient emotion.[6]

Are There Gender and Racial Differences in the General Public's Emotion Culture?

In the general public, males and females have significantly different emotion norms (Gordon 1990; Hochschild 1990), are socially ascribed different emotional roles (Thoits 1986, 1991; Wharton and Erickson 1993), and differ in their personal emotion management strategies (Clark 1990; Denzin 1990; Gordon 1990). Gender differences are also purported in other areas of the sociology of emotion. Affect control theorists

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[6] Although typically some measure of class (i.e. occupation prestige, income, and/or wealth) is included when exploring this type of social stratification, I have chosen to concentrate solely on patient and physician gender and patient race. This is a methodological decision in order to keep the research design and necessary subjects to a manageable size in light of the limited number of physicians available for the study.

(Heise 1979; MacKinnon 1994; Smith-Lovin 1990) believe that sociologist should pay attention to gender differences in emotion, evident by their maintenance of separate fundamental sentiment dictionaries for males and females used in equations to predict emotion outcomes from interactions.[7] Kemper (1978), in his social relations theory of emotion, argues that although the process stimulating emotion is identical for men and women, the elements of power and status involved in this process differ between them.[8] In addition, a few studies have suggested more specific behavioral outcomes associated with these cultural differences.

Women in the enacting of private and public roles are more likely than men to provide positive and direct emotion management which is "affirming, enhancing, and celebrating the well-being of others" (Hochschild 1983, p. 165). Whether this arises from necessity, ability, or simply being more experienced with emotions, it is typically feminine to recognize and deal with their own or another's emotions in a more direct manner.[9] This theme is reiterated in research exploring family and work environments in which women are often found to assume more emotionally oriented roles (Belle 1982, 1987; Bernard 1987; Cancian and Gordon 1988; Coltrane 1989; Ehrensaft 1987;

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[7] For a comprehensive review of affect control theory see MacKinnon (1994).

[8] Kemper has developed the social relations theory of emotion, a structural model which suggests that emotion serves a signal function in social exchanges indicating power and status outcomes for interactants (see Kemper 1978, 1987, 1990, 1991).

[9] This does not imply that males completely abstain from direct emotion management strategies, rather it denotes men's greater reliance on indirect strategies, those which confront the situational or physiological components rather than expressive gestures.

Hochschild 1983, 1989; Wharton and Erickson 1993). Beyond this limited recognition of a gender effect, only a few studies have described the effects of other social characteristics, namely race, on emotion.

Regarding race, much of the existing theoretical and empirical work focuses predominately on an individual's cumulative level of power and/or status ensuing from this and related demographic characteristics (Blau 1964; Collins 1993; Hegtvedt 1990; Homans 1961, 1974; Kemper 1991; Molm 1991; and Ridgeway and Johnson 1990). Thus, none of the reviewed literature explicitly explores the effects of race on emotion or emotion management leaving a remarkable gap in this area of the sociology of emotion.

We can conclude that gender and race have some influence in the general public's emotion culture, with no attention given to the latter in the sociology of emotion. Nevertheless, is it correct to assume that physicians immolate the gendered emotion culture of the general public, let alone influenced by social structural elements, such as gender and race, at all?

Are There Gender and Race Differences in Physician Emotion Culture?

With regards to gender and race, physicians frequently claim adherence to a standard of "universalism" (Parson 1951) in the practice of medicine, treating patients alike without regard to particular attributes or ascribed traits. A significant component of our trust and confidence in doctors rests on this idea of "equal treatment" regardless of gender or race. Nonetheless, according to a recent study, this principle of equal treatment is not adhered to in practice,

> "Although dominant beliefs may have changed over the years, both the realities of gender, race, and class and the cultural assumptions associated with these structural locations continue to play an all-too important role in the way health care is delivered." (Fisher 1995, p. 239)

The prevalence of this universalism and the rather recent emergence for the topic of emotion in medicine itself might explain the limited number of studies in this area of inquiry. This suggests that some doctors may have denied gender and racial influences as well as the role of emotion in the practice of medicine, possibly dissuading social scientists. In addition, much of this literature explores only the effects of physician or patient gender, but not both, and even fewer studies investigate patient race on physician treatment of patient emotion. Hence, it is necessary to include several studies exploring gender and racial effects on more general aspects of the physician-patient interaction.

A physician's gender has a significant influence on his or her medical career and practice. Regarding careers, women are more likely to opt for general practice rather than the more prestigious specialities, typically work in groups located in urban settings, be salaried, work fewer hours and see fewer patients per week (Bryant, Jennett, and Kishinevsky 1991; Colquitt, Smith, and Killian 1992; Notzer and Brown 1995; Shye 1991; Williams, Pierre, and Vayda 1993). Considering this, it is not surprising that male physicians consistently earn more than their female counter-parts (Baker 1996). Gender differences are also observed in academic settings where women advance more slowly than men (Tesch et al. 1995). Hence, research exploring gender differences must

also account for possible differences produced from these gender segregated career/practice paths.

With regard to how the two sexes practice medicine, much of the literature suggests that the quality of health care differs according to physician gender (Colameco, Becker, and Simpson 1983; Fisher 1995; Greer et al.1986; Hall et al. 1990;; Todd 1989; West 1984). In general, female physicians are more aggressive in their routine screening of patients (e.g. breast examinations, cholesterol, mammography, Pap tests, etc.) and other preventive health care measures (Bertakis et al. 1995; Franks and Clancy 1993; Gill 1996; Kreuter et al. 1995; Maheux 1990; Wenrich et al. 1996). More specific examples, women physicians were more likely to prescribe estrogen replacement therapy than men (Seto et al. 1996), rendered more gynecologic procedures (Eliason, Lofton, and Mark 1994), yet less likely to perform flexible sigmoidoscopy (Saad, Pirie, and Sprafka 1994), and had greater delays in treating acute myocardial infarction in emergency medicine (Jackson et al. 1996). Gender differences were also evident in the physician's treatment of patient emotion.

In general, research indicated that female physicians communicate in a more affectively positive manner (Lorber 1984; Roter, Lipkin, and Korsgaard 1991) and are generally more interested in the emotional dispositions of their patients (Maheux et al. 1990; Roos, Gaumont, and Colwill 1977). Regarding specific behavior, the literature also suggested that female physicians were more empathic, feeling with a patient, than male physicians (Arnold, Matin, and Parker 1988; Haar, Halitsky, and Stricker 1975) and provided significantly more sympathy to patients than male physicians (Dickerson

and Pearson 1979; Holder 1979; Shapiro, Boggs, and Melamed 1992; Tolle, Hickam, and Elliot 1985; Wasserman et al. 1984).

Weisman and Teitelbaum (1985), in their comprehensive meta-analysis of studies examining physician gender and the physician-patient relationship, noted several differences between male and female physicians. Specifically related to my study, they show that female physicians are often cited as more nurturing, affectively expressive, and "more highly oriented toward interpersonal relationships and affectivity in medical practice, while men are more reserved and science oriented" (1985, p. 1121).

Similar patterns were also suggested in a recent collection of essays, *The Empathic Practitioner: Empathy, Gender, and Medicine* (More and Milligan 1994), written by several authors, many of whom were practicing female physicians, in which the benefits of empathy in medicine were extolled. These essayists repeatedly present the argument that empathy is predominately a female strategy, with most male practitioners remaining emotionally uninvolved and distant from their patients. In contrast, male physicians are purported to focus on the biological nature of medicine, keeping to a strict scientific-practitioner role, showing, at best, a non-emotional detached concern for patients. Despite the face validity of their arguments, this collection of essays failed to provide a unified theory nor did it offer empirical evidence to substantiate its claims of physician gender differences in empathy. For most of the work in this area of emotion and medicine, the empirical evidence was even sketchier about the effects of *patient gender* on physician treatment of emotion.

As a whole, the institution of medicine (medical, nursing, and allied health professions, health care organizations, insurance companies, etc.) is often criticized for its different treatment of male and female patients, with the latter being treated in what is aptly labeled an "extended patriarchal system" seeking to control and exploit (Fee 1983; Fisher 1989, 1995). Regardless of whether this specific critique of medicine is entirely correct, patient gender does influence physicians' clinical assessments. Colameco, Becker, and Simpson (1983), using standardized case vignettes, in which all variables were held constant, found that by changing gender in clinically identical cases, physicians judged female patients as more emotional. Other studies have similar findings, that physicians do practice a degree of sex role stereotyping with patient emotions (Lennane and Lennane 1973; Locke and Gardner 1969; Nathanson 1975).

Four studies are especially useful in explaining physicians' disparate treatment of male-female patient emotion. Roter et al. (1991) note in their study that physicians gave more psychosocial and biomedical counseling to male patients, however were more emotionally expressive with female patients. Similarly, according to Stewart (1983), doctors have a greater tendency to encourage "tension release" with female patients, often by laughter, and are more apt to ask female patients about their opinions or feelings. Copperstock's (1978) research shows that female patients are twice as likely to receive prescriptions for psychotropic medications. Hooper et al. (1982) notes physician's greater use of empathy with female patients.

However, these four studies are limited in their research on sex difference in physician treatment of patient emotion. Of these four studies, only Roter et al. and

Cooperstock's use of sex as a primary independent variable. In addition, only Cooperstock's study directly investigates physicians' treatment of patient emotion, although it is limited to a single physician emotion treatment strategy for patients: psychotropic prescription patterns. The other three studies provide only tertiary considerations for physician differential treatment of patient emotion. The Roter et al. piece researches communication styles, Stewart - general interaction styles, and Hooper - miscellaneous physician behaviors. Put simply, none of these studies investigate gender and physician treatment of patient emotion forthright. Thus, a great deal of research remains to be done in this field, even more so with regards to the effects of patient race.

Few studies examined the effects of patient race on physician behaviors or treatment patterns regarding medical, let alone emotional, aspects of patient consultations. However, what has been done indicates that, even within the same medical practices, white patients receive care which is higher in technical and interpersonal quality, contains more positive talk, empathy, and are given more information than racial minority patients (Hall, Roter, and Katz 1988; Hooper et al. 1982; Ross, Mirowsky, and Duff 1982; Todd 1989; Tuckett et al. 1985). Shuy (1974) notes that, although many minority patients receive efficient and technically adequate medical care, the delivery of this care is often "emotionally and empathically (sic)" lacking in comparison to other patient populations.

In summary, there was sufficient reason to suspect that gender and race have a bearing on emotion cultures. However, this literature shares many of the same

problems as the work on physician treatment of patient emotion. First, empirical investigations lack theoretically guided systematic approaches for investigating gender and racial effects on either emotion or its treatment. Second, theoretical explorations fail to generate testable hypotheses, let alone the corresponding evaluative data. Third, both empirical and theoretical works do not address the question: Are these gender and racial differences ultimately cultural or structural?

Are Gender and Racial Differences Ultimately Cultural or Structural?

What could be responsible for gender and racial differences in physician treatment of patient emotion? Sociologists generally attribute gender or race differences to either cultural elements or as products of structural discrepancies, the latter of which is often labeled as status differences. Large scale social phenomenon, such as gender and race categories, have both structural and cultural components affecting the individual (Gordon 1990; House 1981; Inkeles 1966) which do not always correlate (Hochschild 1983, 1989; Stearns 1986; Stearns and Stearns 1985), suggesting the presence of separate elements.

Rather than try to argue that either structure or culture determines emotionally linked behavioral patterns, I focus on structural properties as cues that "place" people into categories (Ridgeway and Walker 1995). In other words, I am more interested in how people place others in a power-status hierarchal structure and adjust their behavior according to this social position than the actual behaviors per se.

Thus, I investigate gender and race differences from a stratification/structural perspective rather than a purely socialization/cultural view. In a review of the literature,

Wiley (1995) denotes this trend in sociological social psychology to "place greater emphasis on proximate causes, particularly structural ones" (p. 380) in explaining gender category differences. Omi & Winant suggest that a biological definition of race is "at best imprecise, and at worst completely arbitrary" (1994, p. 55), suggesting race is best conceived as an element of social structure. Does this approach overlook the role of culture? No, it perceives culture as a resource that people draw upon during interactions: culture as an inventory of possible cognitions and behaviors.

According to Hewitt (1979) culture acts as a "stock of knowledge," providing a common lens from which to view social reality and the material from which "human beings construct their acts" (p. 209). In later writings, Hewitt furthers this concept by suggesting culture as the total environment in which human thought and action is embedded, that culture is "both the variety of goals posed by culture and the range of means it affords for attaining them (1989, p. 70). Similarly, Swindler argues that "culture influences action not by providing the ultimate values toward which action is oriented, but by shaping a repertoire or 'tool kit' of habits, skills, and styles from which people construct 'strategies of action'" (1986, p. 273). To reiterate, I am interested in the hierarchy produced by gender and race characteristics and how this structure shapes the amount of emotion management (treatment) and the strategies selected from the physician emotion culture "tool kit."

I assumed that male and female physicians shared a reasonably homogeneous professional culture, of which emotion culture is a part. Several social scientists support this assumption, denoting that the intensity and depth of professional

socialization subjugates individuals to the medical culture (Broadhead 1983; Greer et al. 1986; Lorber 1985; Tolle, Hickam, and Elliot 1985). In my study, emotion culture was further homogenized by employing a standardized roster of physician emotion treatment strategies in the survey instrument presented to both male and female physicians. Hence, physicians had an identical resource from which to draw upon in their interaction with the presented hypothetical patient. Again the assumption here was that male and female physicians share a reasonably homogeneous professional emotion culture. How then do we explain previously discussed differences between male and female physicians in their treatment of patient emotion?

Gender and race are structured parameters (cues) that "situate" members of these categories within the circumstances in which they find themselves (Ridgeway and Walker 1995). As Allan suggests, interactions are influenced by the social context in which people are embedded, which necessitates "locating dyadic relationships within broader structural contexts if they are to be understood satisfactorily" (1993, p. 2). Such is the case for the dyadic relationship between a physician and patient, physicians place patients in a hierarchy and adjust their behavior according to these social positions with patients responding in a similar fashion as well. I discuss exactly how these cues shape physician treatment of patient emotion in the next section.

In review, emotion experiences are comprised of four socially constructed components: situational cues, physical cues, behavioral gestures, and cognitive labels. People are sentient beings, actively reflecting on and manipulating experienced and expressed emotion, informed by the salient emotion culture. Emotion cultures are

somewhat dynamic and consist of an emotion vocabulary, expression/experience norms and rules, and general beliefs/attitudes about emotions. Gender and race structures the doctor-patient relationship and propels the construction of "strategies of action" in physician treatment practices of patient emotion.

Emotion Management Theory

Theoretical work involves an incremental dynamic process of review and revision (Turner 1991). In this section I review the theoretical work on emotion management, refining essential concepts in an effort to develop a more comprehensive and useful theory from which to make predictions regarding physician treatment of patient emotion.

The Content of Emotion Management Theory

Sociologists have identified two forms of emotion management[10]. The first is by the direct management of behavioral expressions in which the external appearance of emotion is contrived. This conception is associated with dramaturgical sociology where expressed emotion is treated as but one facet of impression management for the presentation of self (Goffman 1959). Although this approach has merit, it limits the conception of emotion management as focused on the *surface expression* of emotion, what Hochschild (1983) claims is but a superficial/cosmetic level of emotion. How do

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[10] In order to clarify existing theories in this area, from this point forward *emotion management* will refer to all processes, both self and other focused, of emotion control and shaping.

we explain instances in which an individual seeks to change the intrapersonally *experienced* emotion?

There are several possible reasons why a person would seek to alter his or her *experienced* rather than *expressed* emotion. In general, merely acting a desired emotion is a less reliable and effective method of emotion management. Unless one is an exceptional actor or politician, most observers are better at detecting our underlying (experienced) emotions than we are at hiding them (Buck 1984). Professional theater and film actors recognize these limits of trying to deceive others, referred to as "expression based acting," and often utilize a strategy developed by Constantin Stanislavski (1965) called "method acting," in which actors strive to deceive themselves in order to actually experience the desired emotion rather than attempting to deceive the audience by merely portraying a desired emotion (Hochschild 1983). Lastly, experience tells us that people often want to change their felt emotion, not merely its outward expression. For example, the patient with anxiety wants to feel calm and at peace not simply express it.

As suggested above, a deeper, more substantial and complex form of emotion management, as suggested by Arlie Hochschild (1979), is the control and shaping of the underlying *emotion experience* itself from which outward expressions actually ensue. This second approach offers a potentially more powerful description and explanation of emotion management.

Emotion Work and Emotion Labor

Managing the emotion experience, rather than its outward expression, has the capacity to include all of the components which comprise an emotion, hence amenable to the widely accepted four factor model of emotion discussed earlier. This approach focuses on acts to "change in degree or quality an emotion or feeling" (Hochschild 1979, p. 561). This form of emotion management can be done in private life, called *emotion work,* or for a paid wage on-the-job, termed *emotion labor* (Hochschild 1990). Essentially, the underlying processes for both emotion work and labor are the same, with the only distinction given by Hochschild as the location (private life versus on-the-job) in which they are performed.

As part of her study of families with working women (*The Second Shift,* 1989), Hochschild applied this concept of emotion work done privately at home to the attempts of married couples to cope with contemporary marital and family challenges. Similarly, in an earlier study of how workers manage their feelings on-the-job during troubling times (*Managed Heart,* 1983), she applied the concept of emotion labor and described the increased commodification of emotion in the work field, especially within the service related industries.

Commodification of Emotion

Commodification of emotion occurs when employers or professions encourage/require an emotional product or an emotional display from the employee or professional as part of the goods/services provided to customers. This is most common in the service related industries (e.g. the pleasant flight attendant, the friendly

salesperson, the caring nurse, or the reassuring doctor). A person's ability to elicit the required emotion, either in themselves or others, is bought, sold, and controlled like any other market commodity. In essence, the once private emotional experience or expression comes under the scrutiny and control of an industry, management team, or profession in order to meet specific objectives. Hence, emotions are controlled and shaped to serve the customer, company, or occupation rather than the individual, thus the original or private emotion culture is overruled by the imposition of an institution's emotion culture.

Emotion Directing and Emotion Treatment

For the most part, research has focused on emotion management directed at oneself, and has yet to address the question of how individuals manage the emotion of other people. This is despite Schachter and Singers' (1962) classic study showing the importance of others in our determination of situationally appropriate emotion responses. In addition, sociologists overlook, for the most part, Hochschild's original claim that "emotion work can be done by the self upon the self, the self upon others, and by others upon oneself" (1979, p. 562). Likewise, studies of emotion management and related concepts (coping styles, emotion place markers and claims) also maintain an emphasis on self (Gordon 1989, 1990; Hass 1977; Hochschild 1975, 1983, 1988; Smith and Kleinman 1989; Thoits 1984, 1985, 1990, 1991). Although this interpersonal bi-directional (self-other) process of emotion management is suggested in a few studies (Cahill and Eggston 1994; Clark 1990; Hardesty 1987), an important component in

emotion management theory remains, for the most part, absent: the management of another person's emotions.

In a recent work, Peggy Thoits (1996) recognized this deficiency and illustrated five *small group* strategies to manage the emotions of members: enactment, provocation, physical-efforts, facilitating, and positive group supportive techniques.[11] The *enactment* strategy, often used during the beginning of group sessions, solicited members' concerns or personal problems and then role-played these either singularly (lone enactment) or with others (group enactment). This was done as an attempt to "garner additional details about the situation or issues that were troubling to the worker" (p. 92). In contrast, the main purpose for the *provocation* technique was to elicit strong emotion by deliberately tormenting, either verbally or physically, the featured "worker" for that moment in the group session. *Physical-efforts* were acts (e.g. pounding a fist or one's head into a pillow) to enhance physical arousal for an individual, intending to facilitate a strong emotional expression. *Facilitating* techniques were the manipulation of bodily positions of others to encourage a participant to ventilate (fully express) the aroused emotion, e.g. holding, touching, or screaming with the focal person. *Positive group supportive* techniques were physical efforts (i.e. to actually cradle and rock or massage) to comfort and relax the target "worker."

The above review is an abridged version of Thoits' richly descriptive participant observation data detailing the emotion management strategies of a 1970s psychodrama-

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[11] The emotion management strategies Thoits offers are based on small group not dyadic interactions, which possibly involve different forms of emotion management.

based encounter group. Although some linkages are made to other research in this field, primarily Hochschild's, Thoits does not advance a conspicuous sociological theory from which to explain or generalize the observed strategies, rather she focuses on describing the emotion management of other group members' emotions. Thus, the gap remains in emotion management theory.

From a symbolic interactionist perspective, we can appreciate the importance of "other focused" emotion management in that "self-control like all else depend on other people. Our self is pointed out by others, and our self-control is in large part guided by others." (Charon 1992, p. 85). Self-control is really a matter of other-control "...at that point at which he first begins to act toward himself in more or less the same fashion in which he acts toward other people..." (McCall and Simmons 1978, p. 54). In essence, in order to control (manage) our own emotions we must be able to control the emotions of others, an overlooked point in previous emotion management work.

To fill this theoretical gap, bringing the *other person* back into emotion management theory, I propose the concept of *emotion directing*, the management of another person's emotion in private relationships. Appreciating Hochschild's differentiation between private and work lives, a second concept is required: emotion treatment. *Emotion treatment* is defined as the shaping or control of someone else's emotion as part of a client/service provider relationship. For example, the commercial relationships that exist between passenger-flight attendant, customer-store clerk, client-counselor, or patient-physician.

Modes and Foci of Emotion Directing/Treating

I propose that emotion management processes focused on other people work similarly to those oriented toward oneself, having essentially one of two goals: to evoke a desired emotion which is initially absent or suppress an emotion which is initially present (Hochschild 1979). These goals are realized by two general approaches of emotion management: surface and deep acting.

Surface acting is the manipulation of behavioral emotion expressions, thus working from the "outside-in" to alter the expressed and thus the experienced emotion (Hochschild 1990). This is consistent with the dramaturgical approach (Brissett and Edgley 1990), yet strives to change the underlying experienced emotion not merely the expressive gestures. The essential idea is if we mimic (i.e. portray or feign the expressive gestures) the desired emotion, we will eventually experience (feel) that emotion as genuine, thus acting produces feeling. As one physician involved in a previous study stated, "Sometimes I get upset from the day to day human suffering I'm exposed to... but when I put on my lab-coat I act like a professional should, calm and cool, and you know I begin to feel that way" (DeCoster 1997, p. 159).

Deep acting is performed by adjusting the internal components of emotion, hence working from the "inside-out" to manage the experienced emotion (Hochschild 1990). Hochschild identifies four forms of deep acting: *bodily, prompting, focusing, visualizing.* The first, *bodily deep acting*, suggests manipulating one's physiological state to elicit a desired emotion, such as drinking a glass of wine to "unwind." The second form of deep acting involves "prompting ourselves, or narrowing our mental

focus to a particular image or point of reference" (1990, p. 121). *Focusing* is deliberately changing your attention away from the stimulus eliciting the emotion. The last strategy, *visualization,* requires a person to redefine or imagine an event consistent with the intended emotion. Although not specifically testing Hochschild's concepts, Smith and Kleinmans' (1989) study provides examples of how some these deep acting strategies may occur in the practice of medicine. For example, one frequent emotion management strategy of medical students was a constant *prompting* that they were indeed "medical professionals" and should hence act/feel like it (i.e. non-emotional). Another strategy invoked during uncomfortable situations with patients was the students' intense mental *focusing* on a single anatomical part of the patient or the immediate procedure being performed rather than addressing the patient as a whole person (i.e. one with emotions). *Visualization* occurred when students imagined his or her patients as helpless children needing assistance, a conceptualization of the physician-patient relationship commonly referred to as paternalism.

Building upon Hochschild's work, Peggy Thoits (1984, 1985, 1990) developed a comprehensive and explicit framework for emotion management based upon her four factor model of emotion, which is ideally suited for my concept of emotion treatment. Thoits (1990) first defines emotion management approaches as done either in a *behavioral mode* or *cognitive mode,* both similar to Hochschild's surface acting and deep acting respectively. *Behavioral modes* are observable physical actions (i.e. working from the outside-in). A physician employing strategies to treat patient emotion from a behavioral mode may choose to avoid or medicate an anxious patient (More and

Milligan 1994). *Cognitive modes* entail non-observable mental processes to manage emotion (i.e. working from the inside-out), such as visualizing the patient as a helpless child (Groves 1978).

According to Thoits (1984), these cognitive and/or behavioral modes are focused on one or more of the four basic components that combine to form emotion experiences: situational cues, physiological cues, behavioral gestures, and cognitive labels.[12] *Situational cues* are people, objects, or events which serve as stimuli for an emotion, dependent on one's perception and interpretation of the situation, i.e. the definition of the situation. *Physiological cues* are physiological changes in a person that become associated with a given emotion experience. *Behavioral gestures* are observable facial or bodily expressions corresponding to the emotion experience. *Cognitive labels,* are names applied to the specific configuration of each unique set of components tying them together. To demonstrate, the configuration some patients might define as *fear* (cognitive label) could consist of imagining himself or herself being wheeled into an operating room and seeing the surgical instruments (situational cues), mindful of a rise in blood pressure and increased heart rate (physiological cues), and aware of gasping and crying (behavioral gestures). These components are interconnected, although acute awareness of all four is not necessary to have an emotion experience, an example of this regarding fear is being conscious of the diagnosis of

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[12] Interestingly, Thoits views the emotion experience as analogous to other types of experiences (e.g. sexual, entertainment, dining), all of which can be enhanced by greater attention to the multiple factors comprising each.

breast cancer yet unaware of rapid heart and respiratory rates or the furrowed brow and unfocused gaze. It is worth noting that the contents and configurations of these emotion components are socially created and learned, an assumption consistent with the social constructionist approach.

Thoits' four-factor model of emotion and its related management concepts offer multiple points to intervene and alter the presenting emotion of self or others, the latter being my application. Thus, as Thoits (1990) has shown, combining management modes and emotion component foci produces a table of seven applicable, logically feasible, cells for emotion management (see Table 2.1).[13] An important feature of this emotion management theory is the assumption of interdependence between the emotion components. Hence, a change in one has the potential to affect other components and change the complete emotion experience, an assumption supported by empirical evidence (see Thoits 1984 for a review). For example, one prototypical physician treatment strategy for patient emotion is to prescribe a psychotropic medication (Brodaty, Andrews, and Austin 1982). This behavioral mode strategy focuses specifically on changing the physiological cue of emotion, which in turn is expected to alter the patient's experienced emotion.

In review, my study asserts that we manage the emotions of other people as well as our own, using processes which have been commodified within many of the service related industries, including medicine. Existing theoretical and empirical works

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[13] As indicated by Thoits (1984), the behavioral mode is not applicable to the cognitive label of emotion, i.e. it is impossible to behaviorally change a word.

Table 2.1 Framework of the Modes and Foci of Emotion Management

	Mode	
Focus	Behavioral	Cognitive
Situational Cues	Applicable	Applicable
Physiological Cues	Applicable	Applicable
Expressive Gestures	Applicable	Applicable
Cognitive Labels	Not Applicable	Applicable

emphasize *self* emotion management, which I strive to balance by developing concepts focused on *other* emotion management: *emotion directing* and *emotion treatment*. The methods used in these self and other emotion management efforts are quite similar, either cognitive or behavioral in approach and focus on one or more of the components making up the emotion experience (situational cues, physiological cues, expressive gestures, or cognitive labels). I now move to the application of this theoretical framework in conceptualizing physician treatment of patient emotion.

The Process of Emotion Treatment

The study of emotion management is a theoretical "melting pot," the current flash point for which interaction is occurring between several of the existing sociological perspectives. Past theoretical and empirical work established a fundamental conceptual basis of emotion and emotion management, as detailed above. Much of the emphasis for previous work was placed on the *content* (description) of emotion management, appropriate for any new area of scientific inquiry; what awaits investigation now is the guiding *social process*.

Moving beyond description, I intend to explain physician treatment of patient emotion. The physician emotion treatment process is best conceived as a three step procedure, rather than a single behavioral event. First, a physician prioritizes the patient in an effort to ration their own valuable commodities of time and energy: *patient triaging*. Second, a physician determines the presenting emotion: *emotion diagnosis*. Third, the physician selects appropriate emotion treatments: *strategy selection*. In constructing these steps and the underlying social structural process, I rely

predominately on what Theodore Kemper terms the social relational approach to emotion (1978, 1987, 1990).

The social relational approach asserts that humans experience emotion from real, recollected, or imagined outcomes of social interactions. To put it another way, social outcomes serve as relational precursors to a fundamental set of emotions.[14] Interaction participants measure social outcomes via two dimensions, which Kemper suggests underlies all human interactions: power and status. He defines power as the ability to control, dominate, coerce, threat, punish, or assert self over others. Status is the amount of support, giving, friendliness, congeniality, affection, reward, or regard received, i.e. the degree of voluntary deference and compliance accorded an individual from others. The source (causal agent or attribution) one associates as responsible for the power or status (e.g. self, other, or third-party other) also contributes to the overall evaluation of these social relational outcomes. It is the gain, loss, or maintenance of these power-status dimensions and the perceived attributions which produce primary emotion, i.e. that which is initially felt and most fundamental in our emotion experiences. For example, if a person perceives that she had a net loss of power in an interaction and attributes this loss to the other person with whom she had been interacting with, the

[14] Kemper (1987) supports the existence of a set of four primary emotions (fear, anger, depression, and satisfaction/joy) which have ontogenetic primacy, differentiated autonomic patterns, and are culturally universal. These basic emotions, through the social construction process, are then shaped into an infinite array of culturally specific emotions.

resulting emotion would be anger. If she perceived herself in this same interaction as the source of power loss, the resulting emotion for her is anxiety.

Patient Triaging

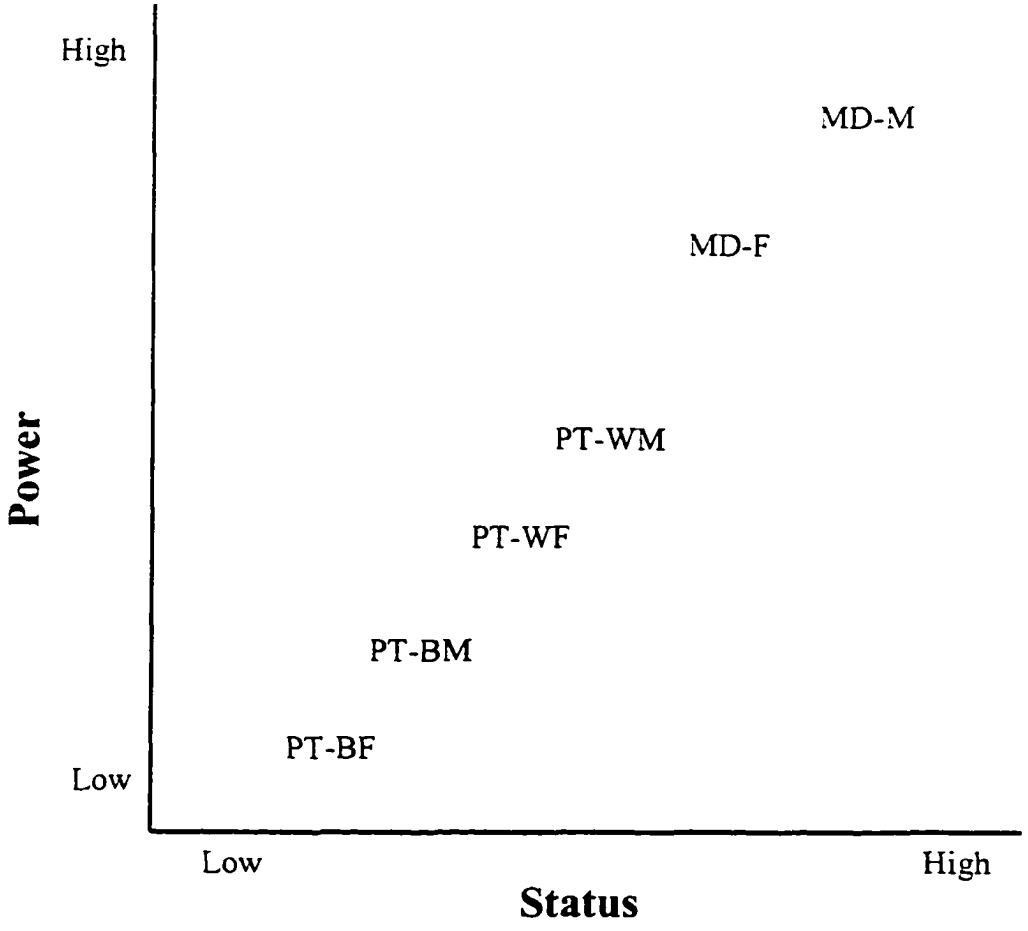
Physician time and energy are finite resources, requiring some form of rationing, a process commonly referred to as patient triaging (Garrett et al. 1993). In medical triage, a common practice in hospital emergency rooms where efficient resource utilization is necessary, patients are prioritized (i.e. rank-ordered, stratified) according to those in most need of care to survive. This is an effective and necessary time management technique also seen in the clinical practices of physicians and other health care professionals. However, when medical indicators become opaque, medical professionals often triage patients according to social characteristics (Eisenberg 1979; Hooper et al. 1982); such is the case in doctors' incidental treatment of emotion.

Physicians triage patients for emotion treatment according to readily available social characteristics: age, race, gender, or social class. I have opted to focus on two characteristics (gender and race) in order to maintain a manageable research design and sample size.

As Kemper suggests, these two diffuse social characteristics can be reduced to their fundamental social elements (i.e. power-status dimensions) and combined, hence forming an appraisal of power and status for an individual's unique combination of social characteristics in relation to others in the interaction. Balkwell (1991) also supports this idea of attending to multiple social characteristics in such a cumulative manner, appreciating the immediate situation and interactants. Put another way, social

structure characteristics do not provide an absolute measure of power and status, rather they locate the individual *relative* to the immediate situation in which he or she is in. For example, a white female family doctor may have higher power and status when interacting with a black female patient but less when conferring with a white male neuro-surgeon.

Establishing the relative location of physicians and patients in this continuum of power and status according to gender and race, all else being equal, requires several assumptions about the import of each structural characteristic. First, with regard to basic roles in the medical consultation, physicians are attributed higher power and status than patients. Second, males are assigned greater power and status than females (Disch 1997; Lips 1997). Third, race is presumed to have greater weight in determining power and status than gender (Hechter 1994, Lieberson 1994), with whites afforded higher power and status than blacks (Omi and Winant 1994). From these assumed values, we can plot the relative, although not absolute, locations of the physicians (via gender characteristics) and patients (via gender and race characteristics) in this two dimensional power-status space (see Figure 2.1). Again, this assumes that all things are equal among the patients themselves, such as age, marital status, social class, health status. Power-status positions are also rank-ordered according to the relative distance between physician and patient (in descending order of power-status difference):



Key:

MD-F = Female physician	PT-WF = White female patient
MD-M = Male physician	PT-WM = White male patient
	PT-BF = Black female patient
	PT-BM = Black male patient

Figure 2.1 Physician-Patient Locations Across Power-Status Continua

White-male physician and black-female patient
White-male physician and black-male patient
White-male physician and white-female patient
White-male physician and white-male patient
White-female physician and black-female patient
White-female physician and black-male patient
White-female physician and white-female patient
White-female physician and white-male patient

I would like to propose a guiding postulate for the emotion treatment triage process: *power-status proximity principle*. Specifically, the closer in this relational space two interactants are the more likely emotion management (directing or treatment) will occur. Typically, people are more inclined to assist others similar to themselves (Dovidio 1984; Taormina and Messick 1983), similarities easily reduced to rudimentary power-status positions and assistance extended to include willingness to direct or treat the other person's emotion. As a corollary, Kemper (1978) notes that the greater the power and status differences between interactants the more depersonalized the interactants become to each other. For example, people of exceptionally high power-status (e.g. physicians, lawyers, professors) are viewed as "larger than life" and people of low power-status are seen as "smaller than life" (e.g. patients, clients, students). In our case, this depersonalization generates a perception of some patients being above or beneath common norms or needs for emotion treatment. From this discussion I assert that the closer a patient and physician are in power and status the greater the likelihood of emotion treatment.

Emotion Diagnosis

In today's accelerated and shortened patient consultation (Todd 1989), limited and ambiguous patient information is increasingly becoming the norm in the practice of medicine, with little time to seek clarification. In no other area of the patient-physician interaction is this truer than with emotional complaints (DeCoster 1997).

Considering this informational deficit, I suggest that physicians often must resort to some fundamental schema for determining (diagnosing) a patient's emotion. This diagnostic method likely consists of interpreting and estimating the personal outcomes for their patients from the presenting illness or injury. I assert that this "fundamental schema" for determining emotion is universal, parsimonious, and reliable, namely Kemper's social relational theory. Hence, when little definitive information is provided regarding patient emotion complaints, physicians diagnose according to the fundamental determinants of emotion - power-status outcomes, of which gender and race are two of the most rudimentary indicators thereof. For example, a chronic disease, such as diabetes, would likely signify a loss of power or status for most people. A *power loss* could ensue from diminished control over one's body (e.g. glycemic and endocrine processes) and life style patterns (e.g. as required by diet plans, eating schedules, and exercise routines now determined by professionals). Conceivably, some patients may view diabetes as a *status loss*, an indication that they are physically abnormal, defective, chronically ill, or unhealthy (Birk 1986). According to Kemper (1990), although relational mechanisms to basic emotions are universal across individuals as well as

societies, it is the socially constructed indicators of power and status (i.e. specific positions, items, behaviors, or events) that are salient between different people.[15]

Doctors are likely to perceive different social relational effects (power-status outcomes) from various medical events for different categories of patients (e.g. white male, white female, black male, or black female), as a consequence of the distinct social histories for each group (Kemper 1978). As discussed previously, gender and race are two fundamental social characteristics often used to classify and distinguish groups of people. Because of the speed-up of medicine and the ambiguity often present in medical information, heuristic short-cuts, based on readily available social characteristics, are used to interpret the immediate situation and the patient's presenting emotion problems. Perceived differences (stereotypes) do not have to be true in order to have an effect on a patient's diagnosis and resulting treatment of emotion. As the frequently quoted W. I. Thomas asserts, "If men define situations as real, they are real in their consequences" (Thomas and Thomas 1928, p. 572), which in our case is the physician's interpretation of the patient situation.[16] Because of the diversity and complexity of medical interactions, this process is best explained by focusing on a

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[15] This universalness of "relational mechanisms to rudimentary emotions" (i.e. anger, anxiety, fear, sadness, satisfaction) refers to Kemper's (1978) notion that gains, losses, or maintenance of power and status in social interactions produce the same basic emotions for everyone. Culture determines the indicators of power and status for people and contorts these basic emotions into an infinite number of possible experiences.

[16] It is assumed that these perceptions are shared equally by both male and female physicians, likely due to common socialization experiences in medical training (Broadhead 1983).

single event common to many practitioners - assisting a patient with the emotional dimensions of a chronic disease such as Diabetes Mellitus.

Physicians likely interpret the psychosocial effects of Diabetes Mellitus differently for male and female patients. For example, I propose that physicians interpret their male patients as experiencing a loss of power from the diagnosis of diabetes. This assertion is supported in several ways. First, men are often attributed as having a "status shield,"[17] buffering them from the loss of status (Hochschild 1978; Lorber 1995) which may result from the diagnosis of diabetes. Second, males are often perceived as placing greater emphasis on power and its related aspects in interactions (Howard et al. 1986; Tannen 1990). Third, men have higher rates of acute but not chronic disease, which in comparison occurs later in life, is shorter in duration, and often results in death (Cockerham 1995). This suggests that men, as a group, are less accustom, experienced, and socialized to the loss of power from a chronic medical condition, hence its greater salience.

Physicians appraise chronic illness for female patients as a loss of status, due in part to several persistent features/experiences of this group. First, the lack of an apparent "status shield," i.e. surplus status to buffer its loss, makes status losses and gains more salient for women. Second, as communication research denotes, women tend to place greater emphasis on status regard (affiliation) in interactions (Tannen

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[17] Status shield is often loosely defined as a combination of power and status (Hochschild 1978; Lorber 1995). In this study I conceptualized it as a status reserve/surplus.

1990). Third, power for women in interactions outside the home has traditionally been thought of as consistently low, suggesting its insignificance for them in non-familial relationships, especially within male dominated medical interactions (Lipps 1997). Fourth, women experience relatively less control over their bodies. This assertion is indicated by women's greater frequency of low acuity illnesses and higher rates of chronic diseases (Cockerham 1995). In addition, the medical industry's substantial medicalization of women's health further suggests that the loss of power is nothing extraordinary for women in medical encounters (Fisher 1995; Todd 1989).

Regarding race, as discussed above, doctors ascribe white patients higher power and status than black patients (Fisher 1995; Omi and Winant 1994). Of course this is only when all things are equal (age, class, disease, education, medical acuity, occupation) for these patients. In addition, physicians interpret a patient's sense of agency differently according to the patient's race.

As noted in Kemper's social relational theory, the source (self, other, or third-party other) from which a person assumes as responsible for power or status outcomes has a significant effect on the resulting emotion. In keeping with his theory, when ascertaining the emotion of another person one typically designates a source as responsible for the power-status outcome. In medical interactions physicians interpret this causal source (responsible agent, locus of control) differently for white and black patients. If we think of this causal source as an attribution, "... a causal inference - judgement about what factors may have caused a particular outcome..." (Howard 1995, p. 98) it is possible to explain it in the following manner.

Within this field of study, the fundamental attribution bias arises from the likelihood for people to assign internal attributions over external attributions in explaining the negative behaviors/events of others (Ross 1977). For example, if a patient is diagnosed with diabetes it must have been his or her fault (e.g. poor health habits, obesity), from the physician's point of view. However, this bias does not always occur, suggesting a deficiency in the fundamental attribution bias to appreciate the effects of basic social categories with the assignment of attribution (Howard 1990, 1995). Consistent with this critique, several social scientists note that self-serving biases can be extended to individuals with which we identify (Franzoi 1996; Mullen and Riordan 1988; Schlenker and Miller 1977).[18] In support of this, Taylor and Jaggi (1974) found that fundamental attribution errors were greater in racially mixed categories, as were self-serving biases in racially similar categories. Applying this to medical interactions, we would expect a physician with a same race patient to assign negative patient events to external attributions of the patient (other or third-party other) but to internal attributions (the patient himself or herself) when with a different race patient. Thus excluding that the physician would see himself or herself as the causal source for a patient's diabetes, a white physician would interpret the loss of power or status (e.g. having diabetes, hypertension, asthma) as attributed to an irremediable third-party other

[18] Self-serving bias is the tendency, with regards to self, to assign an internal attribution for positive behaviors/events and an external attribution to negative events (Franzoi 1996).

(e.g. genetics, God) for white patients and to the individual themselves for black patients (e.g. poor eating, exercise, or other health habits).

I suggest that the resulting product of these perceived gender and racial differences is different emotion diagnoses for these gender and racial groups of patients. Assuming male and female physicians have similar perceptions and interpretations (Broadhead 1983; Greer et al.1986; Tolle, Hickam, and Elliot 1985)[19], the emotion diagnosed for *white males* would be anger, anxiety, or fear, *white females* - anger or depression, *black males* - anxiety or fear, and for *black females* - depression.

Strategy Selection

When applied, physician emotion treatment strategies will correspond with the emotion diagnosed. Maintaining a social relational approach, with power-status outcomes guiding the determination of specific patient emotions, diagnosed emotions guide the selection of strategies to treat these emotions. For example, if a patient is diagnosed as experiencing the emotion of depression, produced from status loss, the physician could select a strategy to enhance status (e.g. acceptance, empathy, or sympathy). However, as Kemper (1978) notes, responses to emotions include those oriented toward the fundamental (power-status) as well as more socially constructed dimensions. With this in mind, not all of the treatment strategies can be identified as

[19] The existence of sex differences in physician behavior is highly debated, with little theoretical consensus nor empirical evidence to arrive at a reasonable conclusion (Eistad 1994; Gray 1982; Miles 1991; Weisman and Teitelbaum 1985).

enhancing either power or status, as I will discuss in the operationalization section of Chapter IV.

General Hypotheses

To reiterate, my study had two general questions regarding physician treatment of patient emotion: what specific strategies do they employ, if at all, and do physician gender and patient gender and race affect this emotion treatment process. With regard to the first question, I hypothesized that physicians utilized specific strategies to treat patient emotion, strategies which were readily identified, unitized, and typologized into mutually exclusive and exhaustive categories consistent with emotion management theory's purported framework.

Predictions for the second research question involved two dimensions of physician treatment of patient emotion: probability and quality. The first dimension sought to determine the general probability (likelihood) for male and female physicians to perform emotion management. Consistent with both constructionist descriptions and structural explanations, I expected female physicians to be more likely than males to provide emotion treatment to their patients. Similarly, white patients and male patients would be more likely to receive emotion treatment from either physician gender group.

Referring to the second dimension, I intended to measure two quality characteristics of the emotion treatment process: the diagnosis and specific strategies employed. Congruent with social relational theory, I expected physicians to diagnosis patient emotion according to the perceived power-status outcomes for each patient. Following in this theoretical vein, the specific strategies selected would correspond with

the perceived relational need, i.e. to increase either a patient's power or status as a means to treat his or her emotion.

CHAPTER III:

METHODS

Introduction

This research sought to empirically investigate physician treatment of patient emotion and the effects of physician gender and patient gender and race on this process. Adequate research methods for any scientific investigation are essential, however several additional concerns were faced by this study. First, as the literature reviewed showed, few social scientists have examined this area of emotion and medicine, therefore some of the measurement methods and instruments relied on were original, although employed methodology well used in other similar research. Second, as with most social science research, the objects of investigation, human beings, can be problematic and at times uncooperative. With these points in mind, I now delineate the methods used in this study.

My study relied on methodologies common to this and similar areas of inquiry (e.g. see Cahill, Fine, and Grant 1995; McCranie, Horowitz, and Martin 1978; and Robinson, Smith-Lovin, and Tsoudis 1994). Taking a positivist approach to the study of emotion and its management (Kemper 1990), I collected empirical data with a survey instrument which solicited physicians' emotion diagnoses and probabilities to use twenty-two treatment strategies in response to a fictional patient vignette. In this chapter I describe the population and sampling techniques, key concepts and variables, research hypotheses, research design, instrumentation, data collection procedures, and conclude with data analysis methodologies employed.

Population and Sampling

The population from which I obtained my empirical data were direct care physicians (i.e. those that have one-on-one interactions with conscious patients), both generalists and specialists, actively practicing in adult out-patient based settings.[20] Direct care physicians usually have ongoing relationships with their patients, i.e. one which occurs for an extended period of time and involves a degree of professional investment, characterized by a level of patient trust and rapport (More and Milligan 1994). Excluded from this population were physicians with practices based entirely in pediatrics, psychiatry, emergency medicine, in-patient groups, or located within military, governmental, or Native-American reservation medical settings. I omitted these physicians as an attempt to control for extraneous variables (e.g. specialized institution, patient population, etc.).

I relied on *convenience sampling* by surveying physicians in two proximate localities: a large Southern capitol city and an adjacent large Southern metropolitan area approximately sixty miles away. I applied the above parameters to key parish medical society membership lists, several hospital staff rosters, and yellow page listings for the two identified localities. From this method, I identified 1403 "direct care" physicians in these two areas, all of which were solicited for participation in the study. For the most

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[20] Physicians typically classified as *generalists* included general practitioners that practice without residency training, family doctors (completed a three year residency program in family medicine), and internist (completed a three year internal medicine residency program). *Specialists* are internal medicine physicians that have completed a fellowship in a specialized field of medicine (e.g. cardiology, endocrinology, pulmonology, nephrology, etc.).

part, I expected participation to be less than the average fifty percent return rate typically received in research using mail-surveys (Dillman 1991), predominately due to the remarkable amount of time required in the daily practice of medicine.

In general, physicians are a rather closed group which makes obtaining access to study them often difficult. However, my access to this population was enhanced by professional relationships with a number of area physicians, academic affiliation with a regional medical center/college of nursing and allied health professions, and preliminary collaborative work with the director and faculty of a local family practice residency program. In addition, the family practice residency program director wrote a cover letter introducing me to physicians and his institution granted me permission to use their letterhead and address for all correspondence.

Operationalization

As Kidder (1981) advises, social scientists must identify concrete representations of abstract concepts in order to measure and study them. In this section I operationalization key concepts and variables as well as the derivation of hypotheses.

Emotion

Emotion, as discussed in Chapter II, was operationalized as an experience comprised of four components: situational cues, physical cues, behavioral gestures, and cognitive labels. However, specific emotion cues were not used in patient case vignettes, an attempt to keep the physician unbiased in his or her diagnosis of the patient emotion. Rather, I relied on nonspecific indicators of patient emotionality across these components, i.e. descriptions of the patient being emotional, feeling upset,

disturbed, emotionally troubled, all without detailing specific emotions. The question posed to physician subjects requested that they "evaluate the likelihood for this patient experiencing each of the following emotions," emotion options provided were: anger, anxiety, fear, sadness/depression (minor, not clinical), and satisfaction/contentment.

Emotion Treatment Strategies

Physician emotion treatment strategies used in the present study were from my earlier work on physician treatment of patient emotion (DeCoster 1997). In the aforementioned study, I identified twenty-two strategies physicians may employ to manage patient emotions, thirteen of which were empirically substantiated. I obtained these from observational, interview, and archival data analyzed with qualitative methods to form a mutually exclusive and exhaustive conceptually clustered matrix (typology) of emotion treatment strategies, organized according to Thoits's (1986) four-factor model of emotion (see Table 3.1). I then operationalized the strategies using the same data (see Table 3.2) consistent with my proposed theory of emotion management, also utilized in this dissertation.

Extending the above research, I then categorized emotion treatment strategies into two groups: strategies to increase power and strategies to enhance status (see Table 3.3). A *power enhancing strategy* was one which intended to encourage or enable a patient to actively assert self over the emotion, i.e. to take action. For example, a physician can suggest a patient exercise to reduce anxiety, refocus to lessen sadness, or explore for the root of expressed anger. In comparison, *status enhancing strategies*

Table 3.1 Typology of Physician Emotion Treatment Strategies

	Mode	
Focus	Behavioral	Cognitive
Situational Cues	Avoid Distract	Accept Empathize Explore Rationalize Reassure Re-define Sympathize
Physiological Cues	Eat Exercise Jocularity Medicate Relaxation	Re-focus
Expressive Gestures	Catharsis	Imagine
Cognitive Labels	Not Applicable	Reinterpret

a. Strategies are typologized according to their intended focus on one of the four components which comprise the emotion experience. Four strategies treat the total patient emotion, hence do not fit within this typology: follow-up, ignore, refer out, and terminate.

Table 3.2 Operationalized Physician Treatment Strategies for Patient Emotion

Strategy	Definition	Application Example
Accept	Acceptance of the presenting situation.	State, "You're not alone, a lot of people have faced similar problems and have done quite well."
Avoid	Complete evasion of stimulus (person, situation, etc...) eliciting negative emotion.	Advise the patient to physically avoid or circumvent behaviors, situations or people which arouse negative emotion.
Catharsis	Active expression of felt emotion.	Talk about how the patient is feeling and encourage them to "let out" (ventilate) emotions.
Distract	Temporarily supplant negative emotion producing stimulus or situation with positive one.	Urge the patient to watch a good movie or television program, read a good book, or do something fun to help to get a break from things for awhile.
Eat	Consumption of food or beverage to alter or produce emotion.	Suggest the patient "treat themselves," such as an occasional good meal or a special snack.
Empathize	Physician understanding/identification with patient emotion experience by the expression and/or verbal proclamation of similar emotion(s).	Express empathy (feeling with the patient) stating, "I've felt that way at times too and probably would feel scared too in the same situation."
Exercise	Physical activity which elicits a cardio-vascular response, from mild to strenuous, for the patient.	Advising the patient to begin an appropriate exercise program to help them feel better and relieve some of the emotional strain.
Explore	Clarify the specific stimulus for the patient's experienced emotion.	Explore with the patient what frightens them the most.
Follow-up	Schedule an additional appointment to monitor patient's emotion.	Schedule a follow-up appointment in a month to reassess how the patient is feeling.
Ignore	Disregard patient expressed emotion.	None
Imagine	Imaginary expression of actual or desired emotion.	Ask the patient to visualize/imagine themselves being happy or expressing happiness.
Jocularity	Stimulate or recommend laughter/humorous response.	Make a mild joke or remind the patient that sometimes "laughter is the best medicine" and advise them to seek out humor (movie, television, book, comedian etc...).

(table con'd.)

Operationalized Physician Treatment Strategies for Patient Emotion

Strategy	Definition	Application Example
Medicate	Recommending or prescribing a psychotropic medication.	Offer a mild psychotropic medication for a trial period.
Rationalize	Discuss the positive or benefitual aspects of a situation.	Explore with patient positive aspects of the situation to concentrate on.
Reassure	Talk which instills confidence in the patient for existing situation.	Reassure the patient, stating for example "You're doing very well and the likelihood of complications are reasonably remote."
Re-define	Re-define the meaning of the presenting situation or stimulus.	State, "You could also look at this situation like this..."
Refer out	Encourage or actually refer patient to a mental health professional for assistance.	Offer a referral to a mental health professional for support and assistance.
Re-focus	Focusing personal energy on behaviors that are seen to have a positive effect on health.	Encourage the patient to focus their behavior and energies on improving their health, to make positive life changes.
Reinterpret	Replace/change emotion label being used for the expressed emotion.	Help them separate physical feelings from emotional feelings and discuss how we can misinterpret one for the other.
Relaxation	Reduce the experienced level of stress for the patient.	Suggest the patient learn basic relaxation techniques, teaching them yourself or referring them out for instruction.
Sympathize	Compassioned encouragement of emotion expression, feeling for the patient.	Express sympathy (feeling for the patient), stating, "Oh, I'm sorry you're feeling scared, but keep in mind we are partners in this and I'm here to help you through it."
Terminate	Complete avoidance of patient emotion by ending interaction.	Ask the patient if they had any other questions and end the meeting.

Table 3.3 Physician Emotion Treatment Strategies According to Social Relational Intent

Strategy Intent	
Increase Power	Increase Status
Avoid	Accept
Catharsis	Empathize
Distract	Reassure
Eat	Sympathize
Exercise	
Explore	
Imagine	
Jocularity	
Rationalize	
Re-define	
Refocus	
Reinterpret	
Relaxation	

intend to bolster a patient's sense of value, regard, or self-worth. For example, empathy communicates understanding for the patient's situation and expressed emotion, reassurance offers support - signaling to the patient that they are going to be ok. Five strategies were excluded from these two categories (follow-up, ignore, medicate, refer-out, and terminate) because these lacked clear intents to enhance either a patient's power or status.

Dependent Variables

To be as thorough as possible, I constructed two forms of dependent variables. The first was a single measure termed *treatment probability.* The second group was factor analytic variables collectively titled *treatment styles.* The *treatment probability* dependent variable intended to measure the overall quantity, rather than quality, of direct emotion treatment offered to particular patients, i.e. the likelihood for a physician to actively assist a patient with his or her emotion within a clinical consultation. I constructed this variable by averaging physician reported probabilities to utilize all twenty-two emotion management strategies, with a higher score on this dependent variable indicating a physician's greater overall likelihood to treat patient emotion. In order to produce a consistent measure of treatment probability, I reverse coded three strategies because they suggest tendencies to *not* treat patient emotion within the immediate consultation (ignore, refer out, terminate). The final product of this reverse-coding and averaging was a numerical score for each physician indicating the overall probability to provide emotion treatment to the particular patient depicted in his or her case vignette. I reported the score along a Likert scale, identical to that used within the

survey instrument, discussed later in this chapter. The Likert scale ranged from *very unlikely* (1) to *very likely* (7) to treat patient emotion.

The second set of dependent variables, *treatment styles*, sought to capture patterns of behaviors also measuring the above concept as well as elucidate other meaningful dimensions of this emotion management process. I developed these variables using factor analytic techniques upon physicians responses to the twenty-two emotion treatment strategies.

Factor analysis attempts to reduce large numbers of variables into a smaller set of variables, also termed factors or latent variables (Everitt 1984). This is achieved by finding patterns among the variances of the original variables and then establishing new variables based on these patterns (McDonald 1985). Specifically, I employed a factor analytical method which extracted the principal components with eigenvalues greater than one (scree test), excluding cases with missing values using listwise deletion. I utilized a varimax rotation method to simplify interpretation of the final factors.

I interpreted these findings by examining the specific factor loadings for all independent variables (strategies) across each of the resulting factors. This was done to determine if the variables with the highest loadings (above .50) had common underlying characteristics, suggesting a meaningful association beyond the purely mathematical relationship found by factor analysis.

To enable cross-factor comparisons, I computed corresponding "factor scores" for each physician subject from these new dependent variables following a method suggested by Marradi (1981). For each new factor analytic variable, strategies

(indicators) with the lowest factor loadings (< .50) were discarded and a factor score coefficient matrix produced for the retained indicators. These were then reviewed to further assess possible indicators that could be dropped from the new dependent variables. I computed final factor scores for each of the new dependent variables with the following formula:

$$F_i = C_1 S_{1i} + C_2 S_{2i} + \ldots + C_n S_{ni}$$

where C_1 is the factor score coefficient for indicator 1, and S_{1i} is the score of individual on indicator 1.

Gender and Race

In this study I dichotomize the concept of gender into two categories synonymous with a biological sex category: male and female (Wiley 1995). This treatment of gender was consistent with much of the existing work in gender or sex differences (for a review and critique see Lorber 1994). Race was also dichotomized as white and black, the predominant approach to operationalizing this variable in medical sociological research (Williams and Collins 1996). Within the vignettes themselves, sex and race were clearly identified in a manner appropriate to a medical patient case presentation of this nature (see patient vignette example in the survey instrument, Appendix A). I constructed four versions of these case vignettes by substituting the racial and sexual identity of the patient as well as corresponding gender nouns, pronouns, and possessives throughout the entire survey (white-male, white-female, black-male, and black-female).

Type of Medical Practice and Setting

As suggested in the Chapter II, the effect of physician sex was likely confounded with other practice related factors, such as the type and practice setting itself. In order to disentangle the effects of these variables, I constructed two independent variables by recoding demographic data obtained from physicians. Physician *type of medical practice* measured the physicians degree of specialization, which I extracted from the open-ended question on his or her type of residency, if any. This data was then re-coded into a dichotomous independent variable with the categories of generalist (i.e. family residency, internal medicine residency only, or no residency training) and specialist (e.g. cardiology residency, endocrinology residency, infectious disease residency, etc.).

Physician practice setting measured whether the physician practiced predominately in a private (independently owned and operated solo or group practice) or an institutional (e.g. HMO, hospital, or academic institution owned and operated) practice setting. I created this dichotomous independent variable (private vs. institutional) by re-coding survey data from the question asking the physicians' current practice setting (again see Appendix A).

Research Hypotheses

Regarding the research questions and general hypotheses discussed earlier, the following hypotheses were proposed:

Hypothesis 1: *Female physicians* will be more likely to *treat patient emotion* when compared with the *male physicians*.

Hypothesis 2: The closer in power/status proximity, the more likely *female physicians* are to *treat patient emotion*. Hence, with physician sex and patient sex and race as the indicators of power/status, the likelihood to treat patient emotion will occur in the following order (descending in degree of probability for treatment):

White-female physician and white-male patient

White-female physician and white-female patient

White-female physician and black-male patient

White-female physician and black-female patient

Hypothesis 3: The closer in power/status proximity, the more likely *male physicians* are to *treat patient emotion*. Hence, with physician sex and patient sex and race as the indicators of power/status, likelihood to treat patient emotion will occur in the following order (descending in degree of probability for treatment):

Male physician with a male/white patient.

Male physician with a female/white patient.

Male physician with a male/black patient.

Male physician with a female/black patient.

Hypothesis 4: White males will be diagnosed as angry, anxious, or fearful.

Hypothesis 5: White females will be diagnosed as angry or depressed.

Hypothesis 6: Black males will be diagnosed as anxious or fearful.

Hypothesis 7: Black females will be diagnosed as depressed.

Hypothesis 8: Emotion treatment strategies will correlate with the diagnosed emotion.

Hypothesis 8a: Patients diagnosed with anger, anxiety, or fear (signifying power loss) will receive emotion treatment strategies to enhance power.

Hypothesis 8b: Patients diagnosed with depression (signifying status loss) will receive emotion strategies to enhance status.

Instrumentation and Data

As mentioned in my discussion of the subject population, I obtained data for this study by surveying physicians practicing in either a large Southern capitol city or an adjacent large metropolitan area. The survey instrument was designed to measure physician diagnoses of patient emotion and the probability that physicians would engage in specific emotion treatment strategies (see Appendix A). The survey instrument presented one of four patient vignettes, which were produced by manipulating the patient's sex (male or female) and race (white or black), with corresponding changes in gender nouns, pronouns and possessives made throughout the instrument. I held several key variables constant in the vignettes: age (forty-two), primary diagnosis (Type-II Diabetes Mellitus), length of the relationship with physician (one year), and present health (excellent). I selected Diabetes Mellitus as the primary diagnosis for the hypothetical patient because of the seriousness of this disease for patients, the relatively high morbidity rate, and its chronic nature, all of which suggests an ongoing relationship between the physician and patient, i.e. a patient the physician would see for the remainder of the patient's life. Other medically-related variables were also controlled to eliminate possible confounding from additional medical problems and

to focus the physician subjects' attention on the patient's emotion complaint rather than other medical elements.

The vignettes were written to resemble in content and form a standard medical case presentation. The construction and pilot-testing of the instrument was done with the assistance of several physicians and residents, the latter of which were all affiliated with a local family medicine residency program. Doctors involved in this construction phase of the questionnaire were ineligible to participate in the study itself. The instrument was also pre-tested using seventy-eight undergraduate students at a local college. Oral and written feedback from both groups on the content, structure, and administration of the questionnaire was considered in the final version of the survey instrument.

Subjects were instructed to closely read the vignette, imagining themselves as the attending physicians. Immediately after the vignette, physicians were asked to evaluate the likelihood for this patient experiencing each of five emotions (anger, anxiety, fear, sadness/depression - minor, not clinical depression, and satisfaction/contentment) according to a seven point Likert scale. The Likert scale ranged from *very unlikely* (1) to *very likely* (7). Physicians were then asked to consider how they would normally respond to the situation. Twenty-two specific emotion treatment strategies were listed from which physician subjects indicated the probability of performing each along a seven point Likert scale, identical to the one used to rate the patient's emotion.

Standard psychometric diagnostic techniques were employed to determine reliability and validity levels of the instrument (Litwin 1995). *Reliability* was determined via pilot testing the instrument with a relatively homogeneous subject pool of undergraduate college students (n = 78), solicited from several of my classes at a local college, relying on the test-retest form of reliability. I administered the questionnaire once at the beginning of a semester then a second time toward the end of the same semester, with approximately ten weeks separating the two administrations. Correlations between the two sets of responses were at .84 percent, above the generally accepted level of .70 (Rubin and Babbie 1989), suggesting that the instrument was reasonably stable.

Validity was determined via *content validity* from four sources. First, I assessed the coherence of the proposed strategies according to the purported theory, existing literature, and previous observations of physicians (see DeCoster 1997). Second, content validity was appraised by reviews from physicians and family medicine residents. Third, feedback was also obtained from the undergraduate pilot test group. Lastly, a number of sociologists, both on and off my dissertation committee, reviewed the strategies and provided input. With this feedback the survey instrument was then altered accordingly.

Research Design

Physician emotion diagnoses and treatment practices were compared across physician sex (male-female) and patient sex (male-female) and patient race (white-black). The resulting two-by-two-by-two design was a between (physician gender) and

within treatment model of analysis (see Figure 3.1) (Kidder 1981). Physician subjects each received one patient vignette from four possible experiment conditions (white-male, white-female, black-male, black-female). Because of the number of physicians initially solicited for the study (n = 1403), I used a *modified systematic assignment* method with a random start to allocate experiment conditions to physician subjects. After randomly selecting the starting position for male and female physician subjects, the four conditions were assigned in the following order: white-male patient, white-female patient, black-male patient, black-female patient.

Data Collection Procedures

All 1403 physicians of the study population were solicited in writing to participate in this study. This initial contact letter was written by the director of a local family practice residency program, affiliated with a state medical school system, introducing the principal investigator to physician subjects (see Appendix B). Approximately seven days following the initial letter the research packet was mailed to all subjects. This packet contained a cover letter, consent form, questionnaire instrument, and a self-addressed-stamped-envelope, mailed in a nine by eleven inch manilla envelope (see Appendix C). A follow-up postcard was mailed approximately ten days following the research packet to all subjects that had yet to respond (see Appendix D). Ten days following this postcard reminder, I mailed a second research packet to thirty male and thirty female physicians, randomly chosen from the list of physicians that had not responded. This was done to ensure that I received an adequate

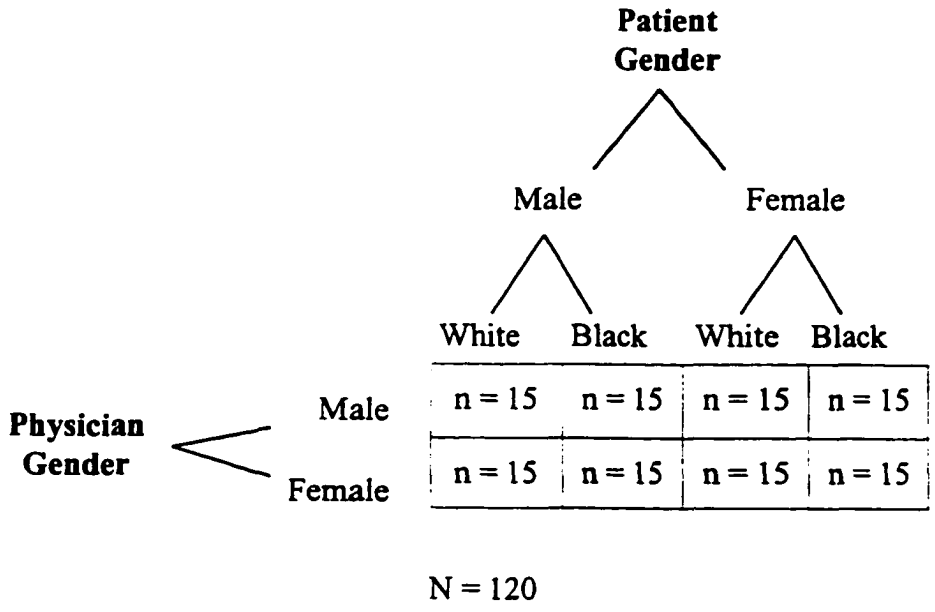

Figure 3.1 Research Design

number of male and female responses to fulfill the experimental design requirements.[21] Throughout the data collection process, I was on "twenty-four call," via digital pager, to answer questions or assist physician subjects with the questionnaire instrument. All physicians were allowed to contact the investigator for further information regarding the study or to obtain a copy of the findings.

Prior to data collection, all return envelopes were assigned a numerical code, not associated or linked in any manner with the questionnaire itself, thus insuring confidentiality. These codes were only used to track questionnaire returns as well as for case identification during data analysis. Written informed consent was also obtained from each physician, utilizing a form consistent with human subject research standards, and securely filed (again see Appendix C).

Data Analysis Procedures

To sufficiently analyze the collected empirical data required several statistical techniques, all of which were common to this kind of sociological research.[22] I began my analysis by using standard univariate statistical methods to describe the personal and practice characteristics of the physician respondents, testing salient means with either the Mann-Whitney U-test or Student's t-test, according to the level of measurement of the data under scrutiny (Babbie 1986; Chase and Brown 1992). After describing the data set, I then employed descriptive and inferential statistics to address the first

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[21] Shortly after completing this second mailing I received a substantial number of completed questionnaires which fulfilled the design requirements.

[22] I performed statistical analyses with a personal computer and S.P.S.S. for Windows (version 6.1).

question: Do physicians use specific strategies to treat patient emotion? I conducted this analysis for the total sample as well as across and within three salient physician sub-groups: males vs. females, generalists vs. specialists, and private vs. institutional based practitioners. Similar descriptive analyses were also completed for the dependent variables, constructed following procedures defined earlier in this chapter. The second research question, do social characteristics of physicians and patients affect the emotion management process, and its related hypothesis required more complex statistical methods.

I analyzed the affects of physician sex and patient sex and race across the proposed three stage physician emotion treatment process (patient triaging, emotion diagnosing, and strategy selection). To test hypotheses related to the *patient triaging* stage (Hypotheses One - Three) with the *treatment probability* dependent variable, I entered the independent variables into a two (physician sex: male, female) by two (patient sex: male, female) by two (patient race: white, black) full factorial analysis of variance (ANOVA) model. I ran a second, more parsimonious, model including only physician related independent variables in a two (physician sex: male, female) by two (type of practice: generalist, specialist) by two (practice setting: private, institutional) full factorial ANOVA, with physician age entered as a covariant. These models were then replicated with the *factor analytic dependent variables*, using appropriate multivariate statistical techniques (MANOVA) (Stevens 1996).

To precisely pinpoint the effects of these physician related variables (age, sex, type of practice, and practice setting), I performed separate ordinary least square (OLS)

regressions for each of the dependent variables. All independent variables were coded as dummy variables, except age. The reference categories for these variables were: physician sex - female, type of practice - generalist, and practice setting - private practice. Variables were all entered in a single step, with listwise deletion for missing values.

To evaluate hypotheses associated with the *emotion diagnosing stage* I again used MANOVA techniques. With emotion diagnoses (anger, anxiety, fear, sadness, and satisfaction) as dependent variables, I tested Hypotheses Four - Seven by entering independent variables into a two (patient sex: male, female) by two (patient race: white, black) MANOVA model. I executed planned comparisons within the MANOVA for patient sex and race across each emotion diagnosis using individual multivariate Bonferroni confidence intervals set at ninety-five percent, chosen in order to control for the number of dependent variables in the model.

I tested my prediction pertaining to the *strategy selection* stage of the physician emotion treatment process, Hypothesis Eight, using Pearson's product-movement correlation technique (Pearson's *r*). I computed correlation coefficients for the five emotion diagnoses in relation to the seventeen treatment strategies categorized as either *power enhancing* emotion management strategies, ways to increase a patient's control (empower) over the emotion experience, or *status enhancing* strategies, methods to bolster a patient's sense of value, regard, or self-worth.

CHAPTER IV:

RESULTS

My two primary objectives for this study were to determine if physicians employed specific strategies to treat patient expressed emotions and whether social characteristics of physicians and patients affected the emotion treatment process. I used descriptive and inferential statistics to investigate these questions as well as test related hypotheses generated in the previous chapter. I begin this chapter by first describing basic characteristics of my physician sample and the sub-groups contained therein (i.e. male-female, generalist-specialist, private-institutional practice). I then address the first research question by presenting my findings on physicians probable use of emotion treatment strategies, including results from factor analysis, which measured additional dimensions of this emotion management process. In the next portion of this chapter, I focus on the second research question by reporting findings associated with the eight hypotheses.

Characteristics of the Physician Sample

A total of 238 physicians participated in my research, which, out of the 1403 physicians solicited, resulted in a gross return rate of seventeen percent. Thirteen of these participants were excluded, nine of whom were outside of this study's population parameters (four practiced in a government facility and five practiced solely with psychiatric or pediatric populations) and four had incomplete questionnaires, defined as more than four essential questions left unanswered. This resulted in an adjusted net return rate of approximately sixteen percent (n = 225). Response rates less than twenty

percent are not atypical in this type of research (Fink 1995), although they certainly affect the generalizability of findings (Dillman 1991). However, this was an acceptable limitation of my research, considering its experimental design, challenging subject population, and the first attempt at applying survey methodologies to investigate physician treatment of patient emotion. Eighty percent of the participating physicians responded within two weeks of receiving the questionnaire (n = 179), sixteen percent within four weeks after receipt of a reminder postcard (n = 36), and the remaining four percent (n = 10) responded within six weeks after receiving a second questionnaire.[23]

Of the 225 physicians contained in my sample, seventy-three percent were male (n = 164) and twenty-seven percent were female (n = 61), the identified population was comprised of eighty-four percent (n = 1183) male and sixteen percent (n = 220) female. Although there were fewer female respondents, their sex specific return rate from the identified populations was notably higher than males, twenty-seven versus sixteen percent respectively. Regarding the two geographic regions identified, twenty-two percent (n = 51) of the final sample consisted of physicians from the capitol city area and seventy-eight percent (n = 174) from the adjacent metropolitan area.

In my sample, male and female physician sub-groups were different across several demographic characteristics (see Table 4.1). Male physicians were significantly more likely to be married, older, to have graduated from medical school earlier, and had

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[23] This second administration of questionnaires was an attempt to increase the number of female respondents, an over sampling of thirty female and thirty male physicians, randomly selected from non-respondents.

Table 4.1 Physician Demographic Characteristics

	Male Physicians		Female Physicians		Total Sample	
	Percent	n	Percent	n	Percent	n
Race						
White, non-Hispanic	81.6	134	82.0	50	81.7	184
Black	3.7	6	4.9	3	4.0	9
Asian	5.5	9	3.3	2	4.9	11
Hispanic	8.0	13	9.8	6	8.5	19
Other	1.2	2	-	0	.9	2
Marital status ***						
Married	87.8	144	60.0	36	80.4	180
Separated	.6	1	3.3	2	1.3	3
Divorced	7.3	12	10.0	6	8.0	18
Widowed	.6	1	1.7	1	.9	2
Single, never married	3.7	6	25.0	15	9.4	21
Age***	48.51	(11.41)	42.33	(8.05)	46.90	(10.96)
Year of graduation***	1974	(12.00)	1981	(8.38)	1976	(11.63)
Years experience***	18.05	(11.87)	9.86	(7.43)	15.87	(11.44)
N		164		61		225

a. Years of experience are post-residency.
b. Numbers in parentheses are standard deviations.
c. * $p < .05$, ** $p < .01$, *** $p < .001$, comparison of male and female physicians.

more years of post-residency practice experience than their female colleagues. Interestingly, significantly more female physicians in my sample were single, never married. The medical practices of male and female physician subjects also appeared different (see Table 4.2). Male physicians treated a significantly greater number out-patients and in-patients on an average day than female physicians in this sample.

Analysis of physician *type of medical practice* failed to find significant demographic differences between generalist (n = 142) and specialist (n = 83) groups (see Table 4.3).[24] Several practice related differences were found. On a typical day, generalists reported seeing an average of nineteen out-patients compared to eleven for specialists, a difference which was statistically significant, although specialists spent significantly more time with these fewer patients (see Table 4.4). In contrast, specialists reported seeing more in-patients. Again, specialists spent significantly more time with these patients than their generalist counterparts (again see Table 4.4).

Regarding the *practice setting*, physicians in private practice (n = 120) were significantly different than physicians in institutionally based practices (n = 105) with regards to both demographic and practice characteristics. Physicians in private practice were older, graduated earlier, and were more likely to have been married than those in institutional practices (see Table 4.5). Expectedly, private practice physicians were

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[24] Generalists included physicians with residency training in family medicine, internal medicine, general practice, or physicians lacking residency training but in general practice. Specialists were physicians with advanced training, beyond a three year internal medicine residency, in a specialized practice (e.g. cardiology, endocrinology, pulmonology, etc.).

Table 4.2 Physician Practice Characteristics

	Male Physicians		Female Physicians		Total Sample	
	Percent	n	Percent	n	Percent	n
Type of practice						
Generalist	61.6	101	67.2	41	63.1	142
Specialist	38.4	63	32.8	20	36.9	83
Practice setting						
Group private-practice	41.0	67	34.4	21	39.7	88
H.M.O.	3.6	6	8.2	5	4.8	11
Hospital owned	15.7	26	13.1	8	15.0	34
Medical school	24.7	41	31.1	19	26.4	60
Solo private-practice	14.5	24	13.1	8	14.1	32
Employment						
Salaried	62.2	102	73.8	45	65.3	147
Self-employed	37.2	61	24.6	15	33.8	76
Other	.6	1	1.6	1	.9	2
Out-patients seen **	17.28	(10.89)	14.95	(7.72)	16.65	(10.17)
Time per out-pt. visit	17.35	(7.02)	18.39	(7.15)	17.63	(7.05)
In-patients seen *	5.56	(5.85)	3.65	(4.26)	5.05	(5.52)
Time per in-pt. visit	15.47	(10.38)	15.71	(10.46)	15.54	(10.38)
N		164		61		225

a. Out/in-patients seen are self-reported daily averages.
b. Time per out/in-pt. visit is self-reported average in minutes.
c. Numbers in parentheses are standard deviations.
d. * p .05, ** p < .01, *** p < .001, comparison of male and female physicians.

Table 4.3 Physician Demographic Characteristics Across Type of Practice: Generalist vs. Specialist

	Physician Type of Practice			
	Generalist		Specialist	
	Percent	n	Percent	n
Sex				
Male	71.1	101	75.9	63
Female	28.9	41	24.1	20
Race				
White, non-Hispanic	84.9	118	77.1	64
Black	5.0	7	2.4	2
Asian	2.9	4	7.2	6
Hispanic	7.2	10	10.8	9
Other	-	0	2.4	2
Marital status				
Married	83.6	117	74.4	61
Separated	1.4	3	1.2	1
Divorced	7.1	10	9.8	8
Widowed	.7	1	1.2	1
Single, never married	7.1	10	13.4	11
Age	46.47	11.76	47.40	9.40
Year of graduation	1976	12.51	1975	9.94
Years of experience	15.84	12.33	15.87	9.66
N		142		83

a. Years of experience is post-residency.
b. * $p < .05$, ** $p < .01$, *** $p < .001$, comparison of generalist and specialist physicians.

Table 4.4 Physician Practice Characteristics Across Type of Practice: Generalist vs. Specialist

	Type of Practice			
	Generalist		Specialist	
	Percent	n	Percent	n
Employment				
Salaried	66.0	93	63.4	52
Self-employed	32.6	46	36.6	30
Other	1.4	2	-	0
Out-patients seen daily ***	19.40	(10.22)	11.82	(8.24)
Time per out-pt. visit ***	16.45	(5.69)	19.79	(8.58)
In-patients seen daily ***	3.74	(4.50)	7.27	(6.36)
Time per in-pt. visit **	13.93	(10.07)	18.00	(10.39)
N		142		83

a. Out/in-patients seen are self-reported daily averages.
b. Time per out/in-pt. visit is self-reported average in minutes.
c. Numbers in parentheses are standard deviations.
d. * $p < .05$, ** $p < .01$, *** $p < .001$, comparison of generalist and specialist physicians.

Table 4.5 Physician Demographic Characteristics Across Practice Setting: Private vs. Institutional

	Practice Setting			
	Private		Institutional	
	Percent	n	Percent	n
Sex				
Male	75.8	91	69.5	73
Female	24.2	29	30.5	32
Race				
White, non-Hispanic	81.8	98	81.6	84
Black	.8	1	7.8	8
Asian	5.7	7	3.9	4
Hispanic	10.7	13	5.8	6
Other	.8	1	1.0	1
Marital status***				
Married	84.3	101	75.7	78
Separated	.8	1	1.9	2
Divorced	9.9	12	5.8	6
Widowed	.8	1	1.0	1
Single, never married	4.1	5	15.2	16
Age**	48.29	(11.88)	45.31	(9.60)
Year of graduation**	1974	(12.66)	1978	(9.96)
Years of experience**	17.36	(12.61)	14.09	(9.65)
N		120		105

a. Years of experiences is post-residency.
b. Numbers in parentheses are standard deviations.
c. * $p < .05$, ** $p < .01$, *** $p < .001$, comparison of private and institutional practice physicians.

more likely to be self-employed and institutional practice physicians salaried (again see Table 4.5). In their medical practices, private practice physicians treated significantly more out-patients than institutional practice physicians, although the amount of time spent with these patients was not significantly different. Observed differences for the number of in-patients as well as the amount of time spent per in-patient visit were not significantly different (see Table 4.6).

Physician Use of Specific Strategies

The first research question asked if physicians utilized identifiable strategies to treat patient expressed emotions. In an attempt to answer this question, I applied descriptive statistics to the collected data. Table 4.7 shows male and female physicians' mean probabilities to utilize the twenty-two emotion treatment strategies proposed. As these means suggest, *explore*, *reassure*, and *rationalize* emotion treatment techniques had the highest probabilities of use among all groups of physicians in my sample (strategies are in descending order of probability). Overall, physicians were least likely to employ *jocularity*, *avoid*, and *ignore* strategies (in descending order of probability), with *eat* strategy replacing *jocularity* in least probable for specialists and private practitioners.

When frequency distributions for the emotion treatment strategies were analyzed graphically, over two-thirds of the strategies were either positively or negatively skewed (see Appendix E for histograms). Seven strategies (*avoid, distract, eat, ignore, imagine, jocularity, medicate*) had positively skewed distributions, indicating that this sample of physicians had lower probabilities to utilize these strategies for treating patient emotion.

Table 4.6 Physician Practice Characteristics Across Practice Setting: Private vs. Institutional

	Practice Setting			
	Private		Institutional	
	Percent	n	Percent	n
Employment***				
Salaried	38.3	46	96.2	101
Self-employed	60.0	72	3.8	4
Other	1.7	2	-	0
Out-patients seen daily***	19.50	(10.00)	13.35	(9.39)
Time per out-pt. visit	16.82	(6.29)	18.59	(7.77)
In-patients seen daily	5.48	(5.83)	4.55	(5.13)
Time per in-pt. visit	14.89	(10.09)	16.27	(10.70)
N		120		105

a. Out/in-patients seen are self-reported daily averages.
b. Time per out/in-pt. visit is self-reported average in minutes.
c. Numbers in parentheses are standard deviations.
d. * $p < .05$, ** $p < .01$, *** $p < .001$, comparison of private and institutional practice physicians.

Table 4.7 Means and Standard Deviations for the Probabilities to Use Emotion Treatment Strategies Across Male and Female Physicians.

	Male Physicians		Female Physicians		Total Sample	
Strategy	$\bar{x}$	S.D.	$\bar{x}$	S.D.	$\bar{x}$	S.D.
Accept	5.39	1.52	5.43	1.49	5.40	1.51
Avoid	2.13	1.32	1.95	1.18	2.08	1.28
Catharsis	5.72	1.41	5.93	1.21	5.78	1.36
Distract ***	2.42	1.48	3.08	1.62	2.60	1.54
Eat	2.55	1.65	2.62	1.61	2.57	1.64
Empathize *	4.98	1.78	5.39	1.84	5.09	1.80
Exercise *	5.46	1.33	5.87	1.12	5.57	1.29
Explore	6.14	1.12	6.31	1.01	6.19	1.09
Follow-up	5.87	1.67	5.69	1.72	5.82	1.68
Ignore	1.70	1.16	1.56	1.04	1.67	1.13
Imagine	2.86	1.65	2.92	1.72	2.88	1.66
Jocularity	2.36	1.47	2.54	1.48	2.41	1.47
Medicate *	3.05	1.66	2.62	1.58	2.94	1.64
Rationalize	5.93	1.28	5.98	1.16	5.95	1.24
Reassure	6.13	1.20	6.30	.88	6.18	1.13
Re-define	4.04	1.73	4.02	1.62	4.03	1.69
Refer out *	3.69	1.92	4.26	1.92	3.85	1.93
Refocus	5.23	1.46	5.34	1.38	5.26	1.44
Reinterpret *	3.81	1.86	3.23	1.78	3.65	1.85
Relaxation	3.95	1.75	4.28	1.53	4.04	1.69
Sympathize	4.83	1.69	5.15	1.29	4.91	1.60
Terminate **	3.61	2.47	2.72	2.09	3.37	2.41

a. * $p < .05$, ** $p < .01$, *** $p < .001$, comparison of male and female physicians.
b. Scores reflect probability to use strategies based on a scale from 1-7, with "1" being highly unlikely and "7" being extremely likely.

As Table 4.7 demonstrates, these seven strategies had mean responses, physicians' reported probabilities for actual usage, below the overall average response ($\bar{x}$ = 4.47). Even when the responses for these seven strategies were combined and averaged, they still fell below the overall average ($\bar{x}$ = 2.94 versus $\bar{x}$ = 4.47). In contrast, nine strategies (*accept, catharsis, empathize, exercise, explore, follow-up, rationalize, reassure,* and *refocus*) had negatively skewed distributions, higher reported probabilities for usage, demonstrating their prevalence among physician subjects (again see Appendix E for histograms). For these nine particular strategies, individual and combined mean probabilities for use were higher than the overall mean probability ($\bar{x}$ = 5.69 versus $\bar{x}$ = 4.47), Table 4.7 shows specific means for each strategy. Responses to four strategies (*relaxation, reinterpret, re-define,* and *sympathize*) approached normal distributions and two (*refer out, terminate*) were prominently bi-modal (again see Table 4.7 for means and standard deviations). These frequency distributions suggest that the responses of this sample of physicians had a notable degree of homogeneity across 16 of 22 emotion treatment strategies (seventy-three percent), something I will discuss in the next chapter.

Female physicians' reported, on average, higher probabilities of using fifteen of the twenty-two emotion treatment strategies, all of which seem to approach patient emotion rather than circumvent it (e.g. *empathy* versus *ignore*), as well as a higher group average probability to treat patient emotions (see Table 4.7) when compared with their male counterparts ($\bar{x}$ = 4.55 versus $\bar{x}$ = 4.44). However, some of these observed differences were not statistically significant. Non-parametric tests revealed that

female physicians were statistically more likely to use the *distract* ($Z = -2.88$, $p < .01$), *empathize* ($Z = -2.00$, $p < .05$), *exercise* ($Z = -2.05$, $p < .05$), and *refer out* ($Z = -2.01$, $p < .05$) strategies (see Table 4.7 for means and standard deviations) than male doctors. For male physicians, results show they were more likely to *medicate* ($Z = -1.83$, $p < .05$), *reinterpret* ($Z = -2.06$, $p < .05$) and *terminate* ($Z = -2.45$, $p < .01$) than female physicians (again see Table 4.3 for means and standard deviations).[25]

Generalists were significantly more likely to utilize the *eat* ($Z = -2.03$, $p < .05$) emotion treatment strategy than their specialist colleagues. Specialists were more likely to use the *reinterpret* ($Z = -2.17$, $p < .05$) strategy than generalist physicians. For generalists, the top three emotion treatment methods of choice were *explore, reassure,* and *rationalize,* in descending order of probability (see Table 4.8). For specialists, the top three strategies were *reassure, explore,* and *rationalize,* again in descending order of probability (again see Table 4.8).

No significant differences were found in physician preferences for various strategies across the two practice settings: private versus institutional (see Table 4.9). For private practice physicians, their top three treatment options for patient emotion were *explore, reassure,* and *follow-up*, in descending order of probability. For institution practice physicians, preferences were to *reassure, explore,* and *rationalize.* Both strategy preference patterns were similar to those for generalists and specialists.

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[25] I utilized the non-parametric Mann-Whitney U-test for independent samples because data were at the ordinal level of measurement.

Table 4.8 Means and Standard Deviations for the Probabilities to Use Emotion Treatment Strategies Across Type of Practice: Generalist vs. Specialist

	Type of Practice				Total Sample	
	Generalist		Specialist			
Strategy	$\bar{x}$	S.D.	$\bar{x}$	S.D.	$\bar{x}$	S.D.
Accept	5.38	1.52	5.39	1.50	5.40	1.51
Avoid	2.12	1.30	2.01	1.25	2.08	1.28
Catharsis	5.78	1.33	5.73	1.42	5.78	1.36
Distract	2.71	1.57	2.40	1.48	2.60	1.54
Eat *	2.69	1.63	2.32	1.57	2.57	1.64
Empathize	5.00	1.79	5.28	1.77	5.09	1.80
Exercise	5.45	1.32	5.75	1.21	5.57	1.29
Explore	6.21	.99	6.12	1.26	6.19	1.09
Follow-up	5.89	1.62	5.71	1.81	5.82	1.68
Ignore	1.61	1.16	1.77	1.09	1.67	1.13
Imagine	2.89	1.70	2.89	1.62	2.88	1.66
Jocularity	2.44	1.46	2.39	1.51	2.41	1.47
Medicate	2.95	1.66	2.92	1.62	2.94	1.64
Rationalize	5.91	1.28	5.99	1.19	5.95	1.24
Reassure	6.17	1.14	6.17	1.12	6.18	1.13
Re-define	3.94	1.63	4.19	1.78	4.03	1.69
Refer out	4.01	1.93	3.63	1.90	3.85	1.93
Refocus	5.11	1.48	5.48	1.33	5.26	1.44
Reinterpret *	3.45	1.84	4.00	1.81	3.65	1.85
Relaxation	4.05	1.63	4.05	1.80	4.04	1.69
Sympathize	4.89	1.57	4.98	1.61	4.91	1.60
Terminate	3.27	2.36	3.59	2.50	3.37	2.41

a. * $p < .05$, ** $p < .01$, *** $p < .001$, comparison of generalist and specialist physicians.

Table 4.9 Means and Standard Deviations for the Probabilities to Use Emotion Treatment Strategies Across Practice Setting: Private vs. Institutional

	Practice Setting				Total Sample	
	Private		Institutional			
Strategy	$\bar{x}$	S.D.	$\bar{x}$	S.D.	$\bar{x}$	S.D.
Accept	5.39	1.53	5.41	1.50	5.40	1.51
Avoid	2.09	1.43	2.08	1.10	2.08	1.28
Catharsis	5.67	1.43	5.90	1.26	5.78	1.36
Distract	2.73	1.65	2.44	1.41	2.60	1.54
Eat	2.55	1.67	2.59	1.60	2.57	1.64
Empathize	4.98	1.82	5.23	1.77	5.09	1.80
Exercise	5.61	1.30	5.53	1.28	5.57	1.29
Explore	6.13	1.12	6.25	1.06	6.19	1.09
Follow-up	5.78	1.71	5.87	1.66	5.82	1.68
Ignore	1.70	1.15	1.62	1.11	1.67	1.13
Imagine	3.03	1.76	2.70	1.53	2.88	1.66
Jocularity	2.56	1.56	2.24	1.36	2.41	1.47
Medicate	3.04	1.67	2.82	1.61	2.94	1.64
Rationalize	5.85	1.39	6.06	1.04	5.95	1.24
Reassure	6.06	1.28	6.31	.90	6.18	1.13
Re-define	4.08	1.63	3.97	1.77	4.03	1.69
Refer out	4.02	1.88	3.64	1.98	3.85	1.93
Refocus	5.24	1.54	5.30	1.32	5.26	1.44
Reinterpret	3.77	1.87	3.51	1.83	3.65	1.85
Relaxation	4.16	1.77	3.90	1.60	4.04	1.69
Sympathize	4.89	1.65	4.93	1.55	4.91	1.60
Terminate	3.59	2.48	3.13	2.31	3.37	2.41

Investigating the effect of age, I found that physician age significantly correlated with a number of treatment strategies (see Table 4.10). Specifically, age was negatively related to *refer-out* ($p < .01$) as well as *reassure* ($p < .01$) and positively related to the *catharsis* ($p < .01$), *ignore* ($p < .01$), *medicate* ($p < .001$), and *reinterpret* ($p < .001$) strategies. From these findings we can surmise that older physicians in this sample were more likely to deal with patient emotions, independent of other professionals, and more likely than younger doctors to medicate patients and encourage them to actively express the emotion.

Probability and Styles of Physician Treatment of Patient Emotion

The second research question, do social characteristics of physicians and patients affect the emotion management process, required the construction of dependent variables. One variable was a summated-scale to measure physicians' likelihood for treating patient emotion - *treatment probability*. Reliability analysis of this scale resulted in a Cronbach's alpha of .73, within the accepted range of reliability. I constructed a second set of dependent variables using factor analytic techniques to capture alternative measures of this concept as well as patterns of physician emotion treatment, detailed below.

I used factor analysis to reveal clusters among the twenty-two emotion management strategies for two reasons: to generate additional dependent variables which may have more accurately captured the essence of my first dependent variable (overall probability to treat patient emotion) and to extract other possible meaningful dimensions pertaining to physician treatment of patient emotion. Specifically, I

Table 4.10 Correlations Among Physician Age and Treatment Strategies

Strategy	Coefficient
Accept	-.092
Avoid	-.043
Catharsis	.195**
Distract	-.108
Eat	.099
Empathize	-.057
Exercise	-.047
Explore	.032
Follow-up	-.010
Ignore	.184**
Imagine	.007
Jocularity	-.016
Medicate	.220***
Rationalize	-.084
Reassure	-.176**
Re-define	.082
Refer out	-.209**
Refocus	.050
Reinterpret	.318***
Relaxation	-.010
Sympathize	-.004
Terminate	.037

a. * p. < .05, ** p < .01, *** p < .001

employed a factor analytical method which extracted the principal components having eigenvalues greater than one (scree test), cases with missing values were excluded using listwise deletion. I utilized varimax rotation to simplify interpretation of the final factors. This analytical technique yielded seven factors from the original twenty-two emotion treatment strategies (see Table 4.11). These seven factors explained sixty-percent of the total variance.

I interpreted these findings by examining the specific loadings for all treatment strategies (indicators) across each of the seven factors. I did this to determine if the variables with the highest loadings (above .50) had some common underlying characteristic(s), suggesting a meaningful association beyond the purely mathematical relationship found by factor analysis. Seven themes emerged from the factors, in numerical order: emotion patronizing, emotion evading, cognitive reconstruction, active physiological alteration, emotion embracing, passive physiological alteration, and extended treatment. I derived most of these terms based on the commonalities among top loading factors, often in terms of their emotion cue focus or behavioral-cognitive approach to manage the patient emotion experience.[26]

The theme *emotion patronizing* originated from the first factor, in which the emotion treatment strategies *accept, empathize, reassure,* and *sympathize* loaded above .50 percent. All four were cognitive strategies focused on an emotion's situational cues.

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[26] As Everitt (1984) points out, latent variables, such as these, only exist within the immediate empirical data, i.e. they do not have a life of their own. These seven factors are unobserved variables explaining the observed correlations. This is important to remember throughout this section.

Table 4.11 Factor Loadings for Emotion Treatment Strategy Indicators

	Factors						
Indicators	Emotion Patronizing	Emotion Evading	Cognitive Reconstruction	Active Physiological Alteration	Emotion Embracing	Passive Physiological Alteration	Emotion Importance
Accept	**.795**	.040	.097	-.094	.051	.000	.002
Avoid	.083	**.641**	.061	-.026	-.195	.214	.257
Catharsis	.132	-.096	.320	.200	**.648**	-.020	.017
Distract	.035	**.822**	-.074	.180	-.004	.025	.044
Eat	.009	.404	.127	.283	-.073	**.502**	-.102
Empathize	**.668**	.069	.124	-.065	.102	.095	-.127
Exercise	.043	.184	.034	**.773**	.150	.036	.069
Explore	.090	-.014	.040	.008	**.819**	.088	.049
Follow-up	.091	.081	-.206	.249	.107	.118	**.645**
Ignore	.294	-.086	-.218	.049	.469	-.285	-.154
Imagine	-.056	.295	**.772**	.155	.163	-.064	-.081
Jocularity	.128	**.651**	.424	.099	-.135	.007	-.112
Medicate	-.016	.066	.095	-.042	.032	**.838**	.034
Rationalize	.711	.022	.044	.255	.128	.096	.200
Reassure	**.647**	.026	-.231	.183	.076	-.202	.270
Re-define	.363	.022	**.559**	.066	.215	.244	.013
Refer out	.104	-.422	.062	.419	-.158	.064	-.135
Refocus	.119	.121	.309	**.670**	.114	-.007	.050
Reinterpret	.157	-.048	**.707**	.114	-.033	.217	.118
Relaxation	.056	.430	.266	.153	.313	.299	-.029
Sympathize	**.554**	.020	.296	.188	.027	-.113	-.146
Terminate	.041	-.073	-.223	.142	.090	.099	**-.803**

a. Factor loadings greater than .50 are in bold print.

I labeled this cluster of strategies as *emotion patronizing* because these strategies only offer support and do not actively involve the patient in managing his or her emotion nor do they seek to alter the emotion experience.

Avoid, distract, and *jocularity* strategies loaded highest in the second factor, all of which were behavioral attempts for a doctor to shun the immediate patient expressed emotion, hence the label *emotion evading*. In essence, this new variable suggested that when an event produces a negative emotion, replace the bad situation with one which generates a positive emotion experience. In the case of *jocularity*, the negative physiological cue was supplanted with a positive one. Again the underlying theme here was to deny, evade, or alter the immediate emotion experience.

Factor three consisted of *imagine, re-define,* and *reinterpret* strategies and was labeled *cognitive reconstruction*. Beyond the common cognitive modality, the defining focus for this cluster of strategies was unclear. In general, these strategies did not involve acceptance of the initial emotion experience, instead these methods were attempts to cognitively modify the emotion into one that was more pleasant.

Factor four strategies (*exercise* and *refocus*) also rejected the initial emotion displayed and sought to change the basic physiological cue of the emotion experience, thus the name *active physiological alteration*. Here the emphasis was on concentrating personal energies or engaging in exercise to modify the emotion experience.

In contrast, the two main strategies for factor five (catharsis and explore) acknowledged and, in different ways, encouraged the patient's immediate emotion experience, hence the label *emotion embracing*. With these treatment strategies, a

physician accosted as well as explored, either experientially or cognitively, the original patient emotion experience. This implied an acceptance of the patient's immediate emotion rather than an attempt to manage away the unpleasant and solicit the positive.

The principal strategies in factor six (*eat, medicate*) dealt with emotion in a similar vein as factor four by attempting to change the physiological cues. But unlike factor four's active approach, this factor used more inert tactics (e.g. encouraging a patient to either consume food or pills to manage their emotion), hence the term *passive physiological alteration.*

Lastly, the two highest loading strategies that made up factor seven were *follow-up* and *terminate*. Conceptually these strategies are diametrically opposed: *follow-up* (i.e. schedule another appointment) insinuates that patient emotion is important enough to warrant additional time from the physician and *terminate* (i.e. end the consultation) implies it does not even deserve the attention in the immediate consultation. These two indicators also loaded in opposite directions, *follow-up* had a positive effect and *terminate* a negative effect, on the concept being measured by this factor. Appreciating the semantic differences as well as contrasting effects of these strategies, factor seven likely measured some general physician value for patient emotion treatment, possibly its rudimentary importance in his or her style of medicine, thus the term *emotion importance.*

Tables 4.12 and 4.13 display the means and standard deviations of these dependent variables for the total sample as well as for various sub-groups. Mean scores on the *treatment probability* measure ranked physicians in the middle of the Likert-scale

Table 4.12 Means (Standard Deviations) For Treatment Probability and Treatment Styles Dependent Variables By Sex, Type of Practice, and Practice Setting

	Sex		Type of Practice		Practice Setting		Total
Dependent Variables	Male	Female	Generalist	Specialist	Private	Institution	Sample
Treatment Probability	4.44	4.55	4.46	4.48	4.47	4.47	4.47
	(.62)	(.61)	(.62)	(.62)	(.64)	(.59)	(.62)
Treatment Styles							
Emotion Patronizing	7.42	7.74	7.46	7.59	7.42	7.61	7.51
	(1.59)	(1.40)	(1.56)	(1.51)	(1.59)	(1.49)	(1.54)
Emotion Evading	2.92	3.22	3.07	2.87	3.12	2.85	3.00
	(1.44)	(1.40)	(1.46)	(1.39)	(1.59)	(1.22)	(1.43)
Cognitive Reconstruction	4.57	4.33	4.39	7.73	4.64	4.34	4.51
	(1.71)	(1.82)	(1.75)	(1.73)	(1.75)	(1.72)	(1.74)
Active Physiological Alteration	6.24	6.54	6.16	6.55	6.32	6.32	6.32
	(1.38)	(1.30)	(1.40)	(1.25)	(1.44)	(1.28)	(1.36)
Emotion Embracing	7.00	7.23	7.08	7.00	6.97	7.17	7.06
	(1.28)	(1.08)	(1.17)	(1.33)	(1.33)	(1.10)	(1.23)
Passive Physiological Alteration	3.52	3.31	3.55	3.28	3.52	3.39	3.46
	(1.65)	(1.60)	(1.70)	(1.52)	(1.68)	(1.60)	(1.64)
Emotion Importance	5.96	5.28	5.74	5.87	5.89	5.64	5.78
	(2.13)	(1.89)	(2.05)	(2.16)	(2.16)	(1.99)	(2.08)
N	164	61	142	83	120	105	225

Table 4.13 Means (Standard Deviations) For Treatment Probability and Treatment Style Dependent Variables By Sub-Groups

	Male				Female			
	Generalist		Specialist		Generalist		Specialist	
Dependent Variables	Private Practice	Institutional Practice	Private Practice	Institutional Practice	Private Practice	Institutional Practice	Private Practice	Institutional Practice
Treatment Probability	4.45	4.73	4.70	4.45	4.48	4.32	4.41	4.56
	(.51)	(.58)	(.86)	(.72)	(.71)	(.55)	(.61)	(.54)
Treatment Styles								
Emotion Patronizing	7.32	7.41	7.44	7.60	7.55	7.90	8.11	7.75
	(1.79)	(1.41)	(1.56)	(1.50)	(1.24)	(1.57)	(.95)	(1.61)
Emotion Evading	3.09	2.68	2.75	3.18	3.58	3.32	3.75	2.35
	(1.69)	(1.12)	(1.37)	(1.41)	(1.54)	(1.04)	(1.74)	(1.13)
Cognitive Reconstruction	4.81	3.93	4.83	4.85	3.92	4.84	5.12	4.15
	(1.79)	(1.55)	(1.75)	(1.57)	(1.69)	(1.85)	(1.20)	(2.09)
Active Physiological	6.07	6.05	6.64	6.22	6.15	6.76	7.35	6.65
	(1.50)	(1.34)	(1.19)	(1.34)	(1.59)	(.77)	(.52)	(1.30)
Emotion Embracing	6.90	7.14	6.99	6.91	7.06	7.57	6.97	7.21
	(1.43)	(1.00)	(1.39)	(1.25)	(.98)	(.79)	(1.47)	(1.38)
Passive Physiological	4.04	3.18	2.99	3.64	2.99	3.74	4.03	3.07
	(1.85)	(1.48)	(1.32)	(1.64)	(1.42)	(1.77)	(1.64)	(1.63)
Emotion Importance	6.02	5.82	6.35	5.63	5.00	5.64	5.93	5.09
	(2.16)	(2.11)	(2.40)	(1.71)	(1.56)	(2.05)	(2.17)	(2.15)
N	56	45	36	27	24	17	5	15

used (1 = very unlikely to 7 = very likely), suggesting that doctors in my sample were "likely" to treat patient emotion.

Addressing the first research question, in brief, the above findings indicate that physicians responded favorably to the majority of strategies offered, thus empirically validating previously identified emotion management strategies for the treatment of patient emotion (DeCoster 1997). Findings also suggested that several physician characteristics influenced the likelihood to utilize these strategies. Results further indicated that the principle dependent variable was reasonably reliable and demonstrated the contributions of factor analysis to understanding this professional emotion management process.

Sex and Race Effects on the First Stage of Emotion Treatment: Patient Triaging

I proposed, in Chapter II, a theoretical framework for the physician emotion treatment process, consisting of these stages: patient triage, emotion diagnosis, and strategy selection. The initial stage of this medical process began with physicians prioritizing patients (patient triaging), measured in this study by the treatment probability dependent variable, an indication of their likelihood to treat a patient's emotion. I predicted that the likelihood for physicians to treat patient emotion (triaging) would be shaped according to physician sex, patient sex, and patient race - hypothesis one (greater emotion treatment by female physicians), two (female physicians' greater emotion treatment to patients closer in power-status) and three (male physicians' greater emotion treatment to patients closer in power-status). I tested these hypotheses in a two (physician sex: male, female) by two (patient sex: male, female) by two (patient race:

white, black) full factorial analysis of variance (ANOVA). No significant main effects were found for these variables on the principal dependent variable, treatment probability (see Table 4.14). Two and three way interactions between independent variables were also insignificant. Findings were equally insignificant when I entered physician type of practice, practice setting, and age variables into the model. Hence, this segment of the analysis failed to support hypotheses one through three.

When the model, however, included only physician variables, analysis uncovered a physician sex effect on *treatment probability*, overall likelihood to treat patient emotion. This occurred, specifically, when I entered the variables into a two (physician type of medical practice: generalist, specialist) by two (physician practice setting: private, institutional) by two (physician sex: male, female) full factorial ANOVA, with age entered as a covariant, results indicated that physician sex produced a main effect, $F(1, 209) = 2.95$, $p < .05$. Thus, when I controlled for age, type of practice, and setting in the model containing the *treatment probability* dependent variable, female physicians were more likely to treat patient emotions than male physicians, $t = -2.11$, $p < .05$ (see Table 4.12). This analysis design also uncovered a three-way interaction effect for physician sex, type of practice, and practice setting, $F(1, 209) = 4.46$, $p < .05$, in contrast to the above. For these eight groups of doctors, male generalists practicing in an institutional setting were the most likely to treat a patient's emotion, female generalists also in the institutional setting were the least likely group, $p. < .01$ (see Table 4.13).

Table 4.14 ANOVA Results for the Affects of Physician Sex and Patient Sex and Race on Physician Probability to Treat Patient Emotion

Source	SS	DF	MS	F	Sig. of F
Bewteen groups					
Patient Race	.07	1	.07	.18	.69
Patient Sex	.10	1	.10	.26	.61
Physician Sex	.38	1	.38	1.00	.32
Pt. Race by Pt. Sex	.54	1	.54	1.43	.23
Pt. Race by MD Sex	.14	1	.14	.36	.54
Pt. Sex by MD Sex	.08	1	.08	.21	.64
Pt. Race by Pt. Sex by MD Sex	.44	1	.44	1.15	.28
Within groups	83.34	219	.38		
Model	2.70	7	.39	1.02	.42
Total	86.05	224	.38		
R^2	.03				

When I replicated the full model, physician sex by patient sex by patient race, using multivariate of analysis techniques (MANOVA) with factor analytic dependent variables (*treatment styles*), physician sex was again significant as a main effect at the multivariate level, $F(1, 103) = 3.36$, $p < .001$. More precisely, results indicated that physician sex had a main effect on the *emotion embracing* factor, $F(1, 103)=15.43$, $p < .001$. In other words, female physicians had significantly higher scores on the emotion embracing factor than their male counterparts ($\bar{x} = 7.23$ versus $\bar{x} = 7.00$), $t = 4.08$, $p. <. 001$.

MANOVA results revealed main effects for an interaction between patient race and sex (experiment conditions), $F(1, 103) = 1.68$, $p < .05$. Specifically, the interaction between patient race and sex had a significant influence on the *emotion evading*, $F(1, 214) = 2.61$, $p < .05$, and *emotion importance*, $F(1, 214) = 4.86$, $p < .01$, factors. The means presented in Table 4.15 illustrate this effect in that physicians assigned black female patients exhibited the highest scores on the *emotion evading* factor and those with white female patients scored lowest, $t = 1.60$, $p < .05$. In addition, physicians with white female patient case vignettes scored highest on the *emotion importance* factor versus doctors with black female patients, $t = 2.21$, $p < .01$. In this same vein, physicians with white male patients scored lowest on *emotion evading* and higher on *emotion importance* factors than those with black male patient vignettes.

Building upon the above, I selected ordinary least squares (OLS) regression analysis to more accurately pinpoint the extent that physician sex, age, type of practice, and practice setting affected *treatment probability* and *treatment styles* dependent

Table 4.15 Physician Scores for Emotion Evading and Emotion Importance Factors Across Patient Sex and Race Conditions

	Emotion Evading		Emotion Importance	
Condition	$\bar{x}$	S.D.	$\bar{x}$	S.D.
White-male patient	2.91	1.46	5.85	2.01
White-female patient	2.87	1.37	6.13	2.03
Black-male patient	3.05	1.25	5.53	2.22
Black-female patient	3.12	1.62	5.66	1.99

variables. Each of the eight dependent variables were separately regressed on the above mentioned four independent variables. All independent variables were coded as dummy variables, except age. The reference categories for these variables were: physician sex - female, type of practice - generalist, and practice setting - private practice. Variables were all entered in a single step, with listwise deletion for missing values.

Table 4.16 reports coefficients from the eight regression equations for *treatment probability* and *treatment styles* dependent variables. The effects of physician age are apparent across four of the eight dependent variables. Age reduced physician scores for *emotion evading* and increased ratings for *cognitive reconstruction* as well as *passive physiological alteration* (e.g. prescribing a psychotropic drug) of a patient's emotion experience. Thus, older doctors were less likely to avoid a patient's emotion and more likely to manage it with cognitive strategies or by more traditional means (i.e. medicating). Private practice produced a negative effect on the degree physicians evaded patient emotions, i.e. physicians in private practices were less likely to avoid emotion than those practicing in institutional settings. Regarding physician sex, being male reduced a doctor's score on the *emotion evading* and *emotion embracing* factors, yet increased his score for the *emotion importance* dimension. Whereas a male doctor was less likely to evade patient emotion and had a higher rating on the *emotion importance* factor, being female resulted in the opposite effect on these two dimensions. Both of these findings are counter to earlier predictions and results, both my own as well as those from other social scientists (see Chapter II for a review). However, being

Table 4.16 Coefficients for Regression of Dependent Variables on Physician Age, Sex, Type of Practice, and Practice Setting

	Dependent Variables															
Independent Variables	Treatment Probability		Emotion Patronizing		Emotion Evading		Cognitive Reconstruction		Active Physiological Alteration		Emotion Embracing		Passive Physiological Alteration		Emotion Importance	
	b	β	b	β	b	β	b	β	b	β	b	β	b	β	b	β
Age	.004	.086	-.011*	-.124	-.020***	-.218	.018**	.200	.005	.063	.001	.015	.023***	.262	-.001	-.018
	(.004)		(.006)		(.006)		(.006)		(.006)		(.006)		(.006)		(.006)	
Physician Sex	-.161*	.011	-.056	-.127	-.290*	-.024	.109	.047	-.229†	-.101	-.339**	-.147	.142	.063	.440**	.195
	(.099)		(.161)		(.155)		(.158)		(.160)		(.162)		(.155)		(.158)	
Type of Practice	.016	.013	.058	.028	-.246*	-.118	.254*	.122	.166	.081	-.210†	-.100	-.080	-.039	.058	028
	(.087)		(.142)		(.136)		(.139)		(.141)		(.142)		(.136)		(139)	
Practice Setting	.014	-.113	.138	.068	-.276*	-.137	-.181†	-.089	.091	.045	.074	.036	.110	055	-.070	-.035
	(.086)		(.140)		(.134)		(.137)		(.138)		(.140)		(.134)		(.137)	
R^2	.015		.025		.103		.077		.020		.033		.080		.039	

a. Numbers in parentheses are estimated standard errors.
b. Type of practice, practice setting, and physician sex are dummy variables; omitted categories are general practice, private practice setting, and female.
c. † $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$ (one tailed tests).

male decreased a physician score on the *emotion embracing* factor, a result more congruous with earlier predictions.

Thus far, analyses revealed that physician sex did indeed influence, for the most part in the direction predicted, a physician's probability to treat patient emotion when age, type of practice, and practice setting were controlled. However, an interaction among these three variables upon the probability to treat patient emotion demonstrated that physician sex differences were more complicated, possibly the result of a physician's type of practice, practice setting, and sex. When factor analytic dependent variables were entered into an MANOVA, physician sex was again shown to have a significant effect, this time on the factor labeled *emotion embracing,* which also supports hypothesis one. MANOVA results also uncovered an interaction effect between patient sex and race on *emotion evading* as well as *emotion importance*, in directions consistent with the essence of hypotheses two and three. The next phase of my analysis, concentrated on the second theoretical stage of the emotion treatment: emotion diagnosis.

Sex and Race Effects on the Second Stage of Emotion Treatment: Emotion Diagnosing

In general, physician responses to anger, anxiety, fear, and sadness emotion diagnoses were all negatively skewed, the exception being the emotion diagnosis of satisfaction which was positively skewed (see Figure 4.1). Thus, my sample of physicians were typically diagnosing the patient depicted in the vignette as *very likely*

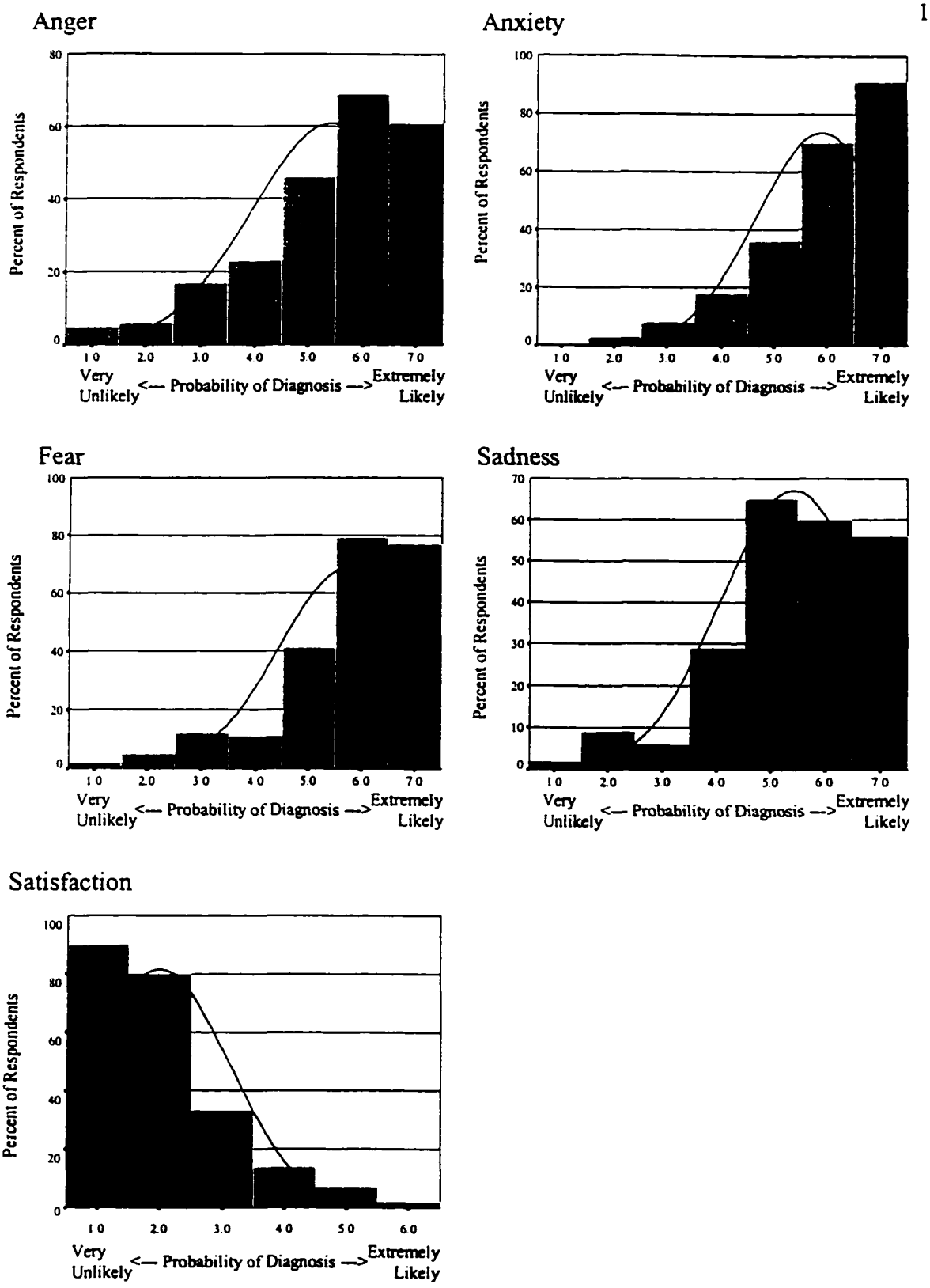

Figure 4.1 Histograms of Response to Emotion Diagnoses

experiencing all four of the negative emotions (anger, anxiety, fear, and sadness) and *very unlikely* experiencing the sole positive emotion (satisfaction).

In this portion of my analysis I evaluated hypotheses four through seven which predicted emotion diagnoses according to the effects of patient sex and race: *white males* - anger, anxiety or fear, *white females* - anger or depression, *black males* - anxiety or fear, and for *black females* - sadness/depression. With the five emotion diagnoses as dependent variables, I tested these four hypotheses by performing a two (patient sex: male, female) by two (patient race: white, black) multivariate analysis of variance (MANOVA) model. Interaction and main effects for patient sex and race were insignificant in the full factorial MANOVA model. However, when MANOVA evaluated the dependent variables separately, results indicated an interaction effect for patient race by patient sex, namely the experiment conditions, on the emotion diagnosis labeled *fear*, $F(1, 108) = 3.35$, $p < .05$.[27] As Table 4.17 indicates, white male patients were the most likely to have their emotions diagnosed as *fear* ($\bar{x} = 5.97$), then black females ($\bar{x} = 5.87$), black males ($\bar{x} = 5.61$) and white females ($\bar{x} = 5.57$), $p. < .05$. Results also revealed a main effect for patient race on the emotion diagnosis of *satisfaction*, $F(1,222) = 6.75$, $p < .01$. Specifically, physicians reported a higher probability for white patients to experience the emotion of satisfaction ($\bar{x} = 2.13$ and $\bar{x} = 2.28$) than black patients ($\bar{x} = 1.89$ and $\bar{x} = 1.76$), $t = 2.59$, $p. < .01$, means are for

[27] I performed planned comparisons within the MANOVA for patient sex and race across each emotion diagnosis using individual multivariate Bonferroni confidence intervals set at ninety-five percent. I chose this method in order to control for the number of dependent variables in the model.

Table 4.17 Means and Standard Deviations for Emotion Diagnoses Across Physician Sex, Patient Sex and Patient Race

		Male Physicians		Female Physicians		Total Sample	
Emotion	Patient	$\bar{x}$	S.D.	$\bar{x}$	S.D.	$\bar{x}$	S.D.
Anger	White-male	5.58	1.37	5.88	1.50	5.66	1.40
	White-female	5.34	1.60	5.13	1.36	5.30	1.50
	Black-male	5.08	1.71	6.05	1.39	5.40	1.67
	Black-female	5.33	1.26	5.18	1.55	5.29	1.34
Anxiety	White-male	5.73	1.30	6.35	1.06	5.90	1.26
	White-female	5.84	1.26	5.87	1.36	5.85	1.26
	Black-male	5.63	1.36	6.42	.82	5.89	1.44
	Black-female	5.87	1.14	6.18	1.19	5.95	1.15
Fear	White-male	5.71	1.42	6.65	.61	5.97	1.32
	White-female	5.53	1.47	5.75	1.28	5.57	1.42
	Black-male	5.26	1.55	6.32	.82	5.61	1.44
	Black-female	5.71	1.12	6.29	.77	5.87	1.06
Sadness	White-male	5.27	1.34	6.12	.78	5.50	1.26
	White-female	5.11	1.48	5.13	1.55	5.11	1.48
	Black-male	5.08	1.26	6.16	.90	5.44	1.25
	Black-female	5.27	1.42	6.35	1.00	5.56	1.40
Satisfaction	White-male	2.16	1.36	2.06	.85	2.13	1.24
	White-female	2.34	1.24	2.00	.93	2.28	1.19
	Black-male	1.97	1.15	1.74	.99	1.89	1.25
	Black-female	1.82	.78	1.59	.94	1.76	.82

male and female patients respectively. MANOVA failed to find additional effects for patient sex or race on the other emotion diagnoses (anger, anxiety, and sadness).

In brief, analysis uncovered little support for my predictions of sex and race effects on emotion diagnosis (Hypotheses 4-7). Only one prediction was accurate, white males being diagnosed as fearful. Patient race significantly affected the emotion diagnosis of satisfaction, although this finding was unpredicted.

Correlations Between Emotion Diagnosis and Treatment Strategies in the Third Stage of Emotion Treatment: Strategy Selection

Lastly, correlations produced modest support for hypothesis eight (the association of emotion treatment strategies with emotion diagnosis). I hypothesized that emotion diagnoses associated with a perceived loss of power for the patient (anger, anxiety, and fear) would be correlated with power-enhancing emotion management strategies (Hypothesis 8a).[28] Data analysis found that three of the thirteen strategies categorized as power-enhancing (*catharsis, explore,* and *rationalization*) had significant correlations across all three power-loss emotion diagnoses in the predicted direction (see Table 4.18). Another two strategies (*exercise* and *refocus*) were significantly correlated across two power-loss emotion diagnoses (anger/anxiety and anxiety/fear). And one strategy (*rationalize*) was significantly correlated with a single power-loss emotion diagnosis (anger). The correlations for the remaining seven emotion treatment techniques with the power-loss emotion diagnoses were insignificant.

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[28] Thirteen strategies were originally identified as power enhancing emotion management strategies, ways to increase a patient's control (empower) over the emotion experience (see Table 4.16).

Table 4.18 Correlations Among Treatment Strategies and Emotion Diagnoses

Strategy	Anger	Anxiety	Fear	Sadness	Satisfaction
Accept [S]	.057	.142*	.153**	-.017	-.005
Avoid [P]	-.048	-.000	-.046	.007	.194**
Catharsis [P]	.222***	.227***	.125*	.214***	-.065
Distract [P]	.041	.005	.108	.139*	.224***
Eat [P]	.077	.042	.060	.076	.265***
Empathize [S]	.126*	.216***	.277***	.098	-.065
Exercise [P]	.118*	.116*	.099	.145*	.068
Explore [P]	.164**	.224***	.199***	.115*	-.092
Imagine [P]	.051	.030	.056	-.043	.024
Jocularity [P]	.058	.048	.080	.003	.191**
Rationalize [P]	.175**	.100	.071	.016	.058
Reassure [S]	.045	.082	.042	.029	-.060
Re-define [P]	.100	.012	.074	.111	.042
Refocus [P]	.030	.179**	.140*	.063	.047
Reinterpret [P]	-.029	-.061	-.073	-.098	.078
Relaxation [P]	-.041	-.017	.006	.031	.045
Sympathize [S]	.036	.114*	.144*	.122*	-.045

a. [P] Denotes a power increasing strategy.
b. [S] Denotes a status increasing strategy.
c. * p. < .05, ** p < .01, *** p < .001

In contrast, four strategies were defined as being status enhancing methods (*accept, empathize, reassure,* and *sympathize*), hypothesized as associated with the status-loss emotion diagnosis of sadness (Hypothesis 8b). Only the *sympathize* strategy was consistent with this prediction (see Table 4.7). However, three of these strategies were significantly correlated with several of the power-loss emotion diagnoses as well.

As the above demonstrated, physicians do employ identifiable strategies to treat patient emotions; and a physician's sex does influence the selection of strategies. Likewise, variables extracted from the data set were reliable and provided additional empirical insight into this professional emotion management process, which I elaborate in the next chapter. Furthermore, findings demonstrate the effects of two social characteristics (sex and race) on this growing component in the practice of modern medicine - physician treatment of patient emotion.

CHAPTER V:

SUMMARY AND DISCUSSION

In this dissertation I intended to address two general questions regarding physician treatment of patient emotions. First, do physicians employ specific strategies to treat patient expressed emotions? Second, would physician and/or patient social characteristics affect the probability or form of emotion treatment? Within this chapter I summarize my research findings and discuss what these results might tell us about this professional other-directed emotion management process.

Summary of Findings

Of the 1403 direct care physicians solicited, sixteen percent (n = 225) participated. The resulting sample was comprised of seventy-three percent male and twenty-seven percent female physicians, sixty-two percent generalists and thirty-eight percent specialists, with fifty-four percent of the physicians based in private practices and forty-six percent in institutional practices. Analyses of data from these physicians generated partial answers to the two research questions posed.

Regarding the first research question, results demonstrated that the physicians surveyed did use an identifiable collection of specific methods to treat patient emotion. My results suggested that the twenty-two strategies offered in the questionnaire did exhaust the treatment options typically used by the doctors surveyed.[29] Furthermore,

[29] Although I had provided adequate space for comments at the end of the survey instrument, none of the physician subjects offered additional patient emotion treatment strategies.

preferences for and against sixteen of the twenty-two emotion treatment strategies offered were relatively uniform, even across various physician sub-groups (i.e. male-female, generalist-specialist, private-institutional practices). *Explore*, *reassure*, and *rationalize* emotion treatment techniques had the highest probabilities of use, in descending order of probability, among all groups of physicians contained in my sample. In contrast, theses doctors were least likely to use *ignore*, *avoid*, and *jocularity* strategies, in ascending order of probability, with *eat* strategy replacing *jocularity* for specialists and private practitioners.

My analyses did reveal some significant group differences in preferences for specific strategies. In general, female physicians were more likely than males to use strategies that managed emotion directly, males were more prone to use methods which evaded patient emotion (e.g. *empathy* versus *ignore*). Female physicians were more probable to use *distract*, *empathize*, *exercise*, and *refer out* strategies while males were more likely to use *medicate*, *reinterpret*, or terminate strategies. Comparing the two types of practices, generalists were more likely to use *eat* while specialists preferred the *reinterpret* technique. There were no statistically significant differences in the strategies used by physicians in private practices and institutional settings. Regarding the influence of age, older physicians were less likely to *refer-out* or *reassure* a patient, but were more likely to use the emotion treatment strategies of *catharsis*, *medicate*, *reinterpret*, and *ignore* than younger colleagues.

I constructed two types of dependent variables. The first was a summated-scale to measure physicians' likelihood for treating patient emotion (*treatment probability*), my

principal dependent variable. The second form of dependent variables (*treatment styles)* I constructed using factor analytic techniques. This produced seven variables, defined according to their emergent themes: emotion patronizing, emotion evading, cognitive reconstruction, active physiological alteration, emotion embracing, passive physiological alteration, and emotion importance.

Hypotheses associated with the second question, do physician and patient social characteristics (physician sex and patient sex and race) affect the probability or form of emotion treatment, received some empirical support. My findings supported hypothesis one (greater treatment by female physicians to all patients) in three ways. First, when I included only physician variables (physician age, sex, type of practice, and practice setting) in the ANOVA model, physician sex demonstrated a significant main effect upon *treatment probability*, thus female physicians were more likely to treat patient emotions than male physicians. Second, comparisons of male and female physician preferences across each strategy revealed six significant differences consistent with this hypothesis. Third, MANOVA found a main effect for physician sex at the multivariate level with factor analytic dependent variables (*treatment styles*) and an individual effect on *emotion embracing*, both of which support the basic premise of hypothesis one.

Patient sex and race did not affect the dependent variable - *treatment probability*. However, MANOVA findings with factor analytic dependent variables revealed an interaction main effect for patient sex and race in the full model and separately for *emotion evading* and *emotion importance* dependent variables. Hence, hypotheses two

and three (greater probability of emotion treatment for patients closer to the physician's power-status) received mixed support.

Extending the above analysis, I employed OLS regression analyses to pinpoint the effects of physician sex, age, type of practice, and practice setting upon the emotion treatment process. Results revealed that when the physician was male it significantly reduced his score on *emotion evading* and *emotion embracing* yet increased it for the *emotion importance* measure. Age had a negative effect for a physician's score on the *emotion evading* factor and a positive affect for his or her score on the *cognitive reconstruction* as well as *passive physiological alteration* factors. Practice setting also affected a physician's style of emotion treatment. Working predominately in an institutionally based practice lowered a physician's score on the *emotion evading* factor. Type of practice did not achieve significance in any of the OLS regression models.

My extension of Kemper's social relational theory, where I assumed that physicians would interpret power-status outcomes differently across patient sex and race, was inadequate at predicting patient emotion diagnoses. Specifically, only partial support was found for hypothesis four (greater likelihood of male patients' being diagnosed with fear), none of the other predictions related to hypotheses five through seven received support. It appears that physicians were, in general, just as likely to diagnosis a Diabetes patient presenting nondescript "emotion complaints" as feeling angry, anxious, fearful, or sad, regardless of the patients' sex or race. Physicians did rate the emotion of satisfaction as more likely among white than black patients, a difference that was statistically different, albeit unpredicted.

Partial support was uncovered for the notion that emotion treatment strategies could be categorized as either power or status enhancing and correlated with emotions stemming from either power or status losses, another extension of Kemper's social relational theory. Results of correlational analyses upheld hypothesis eight in seven out of seventeen of the strategies included in this portion of the analysis. The strength of these correlations varied and some were not significantly associated with all predicted emotions. Only the strategies *catharsis*, *explore*, and *sympathize* were significantly correlated with all predicted emotion(s).

In summary, findings related to the first research question offer reasonable insight into physician use of identifiable strategies. Predictions regarding the effects of physician sex received modest support. Yet my research finding are best described as nonconclusive for predictions concerning the effects of patient sex and race on physician treatment of patient emotions (second research question). How might I explain lackluster support for this portion of the second research question and its related hypotheses? Is it the result of methodological or theoretical shortcomings?

Methodological or Theoretical Complications

Was my choice of research methods poorly suited for the research questions? This is indeed possible, although the design, instrument, and analytical techniques used were within the scope and range of what is customary for this type of research (Babbie 1986; Cahill, Fine, and Grant 1995; Chase and Brown 1992; Kidder 1981; Rubin and Babbie 1989; Litwin 1995). Greater reliance on qualitative methods (e.g. non-participant observations, video taping interactions, etc.) may have more precisely

captured physicians' actual behavior, although this methodology has disadvantages too. For example, qualitative data are less generalizable and require substantially more time to collect (for a discussion of these and related concerns see Miles and Huberman 1994). While time and resource limitations discouraged this methodological style, which may have required several years of expensive field work, this is certainly a viable option for a future grant funded project.

If the methodological style was not primarily at fault, could it have been the instrument itself? Specifically, were the vignettes faulty? Medically, the case example was accurate and appropriate for the intended audience, as indicated by physicians whom I collaborated with during its construction. Did the vignettes accurately and with sufficient intensity simulate patient sex and race differences? Ideally, physicians interacting with"real patients" rather than vignettes would be preferable, but for the researcher it presents an appreciable loss of experimental control. Other studies have been quite successful utilizing a vignette form of medical case presentation (e.g. Berstein and Kane 1981, Colameco, Becker, and Simpson 1983; Nightingale et al. 1991), rather than more expensive video recordings of portrayed patient-physician interactions or less controlled naturalistic observations.

Certainly my choice of methodologies did not capture all the nuisances of a real physician-patient interaction. One such omitted element was the role of patient-physician negotiation. According to Berger and Luckman, inferences people have about one another, such as those related to sex and race differences, often "enter into an ongoing 'negotiation' in the face-to-face situation" (1966, p. 31). As Charon describes

it, "... labeling people in interaction is far more complicated, based on subtle, not clearly delineated, clues, and usually subject to a great deal of alteration as we interact" (1992, p. 150). Relatedly, my study's concentration on physicians only, neglected the patient's expectations of emotion treatment by the physician. My data are unable to determine if physicians are reacting to a patient's power-status position relative to their own or conforming to the assumed expectations held by these various groups of patients (i.e. white-male, white-female, black-male, black-female). Patients' preferences for or against different emotion treatment strategies are also unknown. Unfortunately, failing to account for this and other emergent characteristics of human interactions is a fundamental limitation of the quantitative approach (Patton 1990).

My use of convenience sampling presents another possible limitation, the generalizability of findings to other physicians. Participating physicians in this research may have had a greater interest in the patient emotions than non-participating physicians. They also could differ in other personal or practice characteristics from their colleagues (e.g. medical school or residency program attended, professional experiences, etc.). However, this limitation does not apply to all of my findings, given the experimental research design with random assignment to categories (Babbie 1986).

Another factor which may have affected my results was the social desirability bias (Rubin and Babbie 1989). The social desirability bias suggests that subjects in survey/questionnaire based research can feel pressured to respond as they "should" not as they actually "would", thus failing to capture true behavior (Shaughnessy and

Zechmeister 1985). If this is true, then what I have measured was not physicians' real responses but some "ideal" standard for behavior, which, as the data illustrate, is positive with regard to physicians treatment of patient emotion. Thus, my findings offer empirical evidence, to some extent, for an ideological shift in medicine toward the acceptance of emotion.[30]

It is also possible that I failed to theoretically account for other confounding factors, such as the medical school experience itself. The relatively high level of homogeneity among physicians responses may be a function of the professional socialization that occurs in medical schools and residency/fellowship training programs. As some sociologists suggest, the intensity and demands of medical school are such that it requires almost total abandonment of one's self to the professionalization process and unconditional acceptance of the medical paradigm (Broadhead 1983; Martin, Arnold, and Parker 1989; Potts, Katz, and Brandt 1986; Smith and Kleinman 1989).[31] This in itself may have several consequences for my findings.

The relatively modest differences between male and female physicians could be accounted for by the often "neutering if not masculinizing effect" (Broadhead 1983, p. 49) of medical socialization on female physicians. As Campbell noted, "The 'culture' of the medical school apparently promotes the hypertrophy of certain

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[30] I discussed this supposed shift from traditional to contemporary perspectives on the role of emotion in medicine in Chapter I.

[31] Broadhead's work, given its time period, would seem particularly germane to describing the medical school milieu of physicians in my study considering the majority graduated sometime between the late 1970s to early 1980s.

(traditional) 'male' attitudes and behaviors and is often supported by a men's club atmosphere" (1973, p. 22). As these authors suggest, for either sex to survive medical school they had to espouse the predominate ideologies, which for many of the physicians in my sample was a belief system dominated by a masculinized scientific approach, considering their year of medical school graduation was at a time when females constituted a significant minority in academic medicine (Martin, Arnold, and Parker 1989). Whether physician-reported attitudes for treating patient emotion were congruent with actual behavior remains unanswered.

Ahother prevalent concept in medical ideology, possibly influencing my work, is the principle of universalism (treating patients alike without regard to particular attributes or ascribed traits), discussed in Chapter II. If medical schools have done a reasonable job of instilling this concept as part of a physician's ideological framework, we would not expect to find predjudism based upon a patient's sex or race. As discussed in Chapter II, however, several social scientists propose that this ideological principle is not always adhered to in actual practice (Colameco, Becker, and Simpson 1983; Copperstock 1978; Fee 1983; Fisher 1995; Hall, Roter, and Katz 1988; Hooper et al. 1982; Lennane and Lennane 1973; Locke and Gardner 1969; Mendelsohn 1981; Nathanson 1975; Ross, Mirowsky, and Duff 1982; Roter et al. 1991; Shuy 1974; Stewart 1983; Todd 1989; and Tuckett et al. 1985). Although universalism may not always be maintained in the day-to-day practice of medicine, my results may reflect its continued salience, at least in principle, for many practicing physicians. The question of physicians' adhering to this concept of universalism in the actual treatment of patient

emotion as well as other facets of medical care presents additional opportunities for future research, especially if these ideologies could be measured then compared with observed behaviors.

There are a number of additional social characteristics people may use to structurally place others in relation to themselves during social interactions (e.g. age, education, ethnicity, occupation, social class). Social class, in particular, is often considered as the most fundamental and decisive element involved in stratification (Grusky 1994), a variable excluded from my research design that may have had a significant effect on these findings.

Many sociologists suggest that class shapes everything from life-styles and consumption patterns to personality and attitudes (DiMaggio 1994). By not including a class variable or, at the very least, controlling for it in the patient vignette, left this important determinant of social structure open to speculation by respondents. Physicians may have made any number of assumptions about the patient's class according to gender, medical diagnosis, race, or assumed class similarity with patients from their own practices. An assumed social class for the patient could have significantly altered their position relative to the physician in the two dimensional power-status space and hence the outcomes of the hypothesized professional emotion management process. Beyond an independent effect, class could have interacted with gender and race, yet without this variable included in the analysis these potential effects are unknown. Thus, to accurately explore the net effects of gender and race on

physician treatment of patient emotions, future research needs to include some measure of social class.

Although all research suffers from some degree of incompleteness, my work could be improved if the above factors were addressed in future studies. Having outlined these concerns, what do my findings tell us about physician treatment of patient emotion?

Advancing Knowledge About Physician Treatment of Patient Emotion

Since my research findings offered only partial answers to the main questions, what else might they tell us about physician treatment of patient emotions? I believe my project made several contributions to this field of research.

First, it produced distinctive insight into the emotion treatment tendencies of physicians. None of the existing research explored the treatment of patient emotions in medicine with quantitative data from practicing physicians. Furthermore, none of the previous studies had collected any such empirical data in quantity from both male and female physicians.

We can assume that physicians in this sample were not new to the practice of medicine. For the most part, these were mature clinicians in the prime of their medical practices, with a mean age of forty-six and an average of sixteen years of post-residency experience. These physicians may represent a unique cohort, the last group to be educated in a time when males dominated the medical environment, where paternalism was the norm, and the notion of practicing "good financial medicine" was still in its infancy. It was with these doctors that I explored how patient emotions were treated and

what effects, if any, social characteristics would have on the probability or form of emotion management.

Second, this work filled two gaps in the literature; it systematically examined the strategies physicians use to treat patient emotions and generated additional empirical support for existing research. My work uncovered reasonable evidence for the notion that physicians draw upon specific strategies to treat patient emotion. Findings indicate that physicians indeed utilize an identifiable collection of methods to treat patient emotion and that the twenty-two strategies offered were an exhaustive list of strategies for this sample of physicians. The latter is a reasonable assumption considering the list exhausted possibilities from several sources: existing literature, consulted physicians, as well as the research subjects themselves. The fact that physicians responded favorably to most of the twenty-two strategies lends further credit to previous research that originally identified many of these emotion treatment strategies (e.g. DeCoster 1997; Fuller and Geis 1985; Locke 1996; Smith and Kleinman 1989).

Researchers, educators, and clinicians now have a theoretically sound and empirically supported inventory of emotion treatment methods. These may be applied and their effectiveness tested across various patient populations, medical situations, or emotions. For example, which strategies are most effective for low-literacy clients, trauma victims, or anxious surgery patients? Could teaching medical students and residents these explicit techniques enhance their comfort and skill when interacting with patients? For practicing physicians, would these methods heighten patient confidence and satisfaction? Would this in turn improve patient-provided information,

questioning, compliance, as well as decrease "doctor shopping," as the literature reviewed in Chapter I suggested?

These findings could also be interpreted as supporting previous beliefs on the strength of medical socialization (Broadhead 1983; Martin, Arnold, and Parker 1989; Potts, Katz, and Brandt 1986; Smith and Kleinman 1989). Specifically, physicians were reasonably homogenous in their preferences for as well as against sixteen of the twenty-two emotion treatment strategies offered, even across the various physician sub-groups (i.e. male-female, generalist-specialist, private-institutional practices). This indicates that the socialization process in medicine is rigorous and effective, as suggested by Broadhead (1983), even possibly for how doctors treat patient emotion, a process that receives little overt attention in medical school and residency programs (Smith and Kleinman 1989), a possible impediment for future work in this area. Future research could explore and compare the affects of other "professional socializations" (e.g. social work, psychology, nursing) on the probability and form of emotion treatment provided patients.

As my research disclosed, male and female physician differences in dealing with patient emotion were more complicated than previously thought. The positive effect of physician sex on male physicians' *emotion evading* and *emotion importance* scores, revealed by regression analysis, brings into question existing theoretical as well as empirical work supporting the idea that emotions are the purview of female practitioners only. This counter-intuitive finding suggests that the stereotype that male physicians are uninterested in the emotional states of their patients, is either inaccurate or is changing,

hence suggesting the need for further investigation by social scientists. My data demonstrated that, in addition to physician sex, a doctor's age, type of medicine practiced, and practice setting influenced the probability and form of emotion treatment provided to patients. Age, in particular, exerted a notable influence, suggesting its salience may be undervalued in explaining other gender differences in medicine (e.g. see Martin, Arnold, and Parker 1989). Thus, male-female physician differences may be more complex than something based solely on sex. As Ridgeway and Diekema (1992) suggested, gender differences may indeed be status differences. Future work would do well to explore the effects of other status elements in medicine, such as prestige of medical school attended, residency/fellowships, technical skill, type of practice, institutional affiliation, social class, ethnicity, success of practice, and so on.

My findings may also indicate an increasing recognition of emotion in the practice of contemporary medicine. When responses were averaged across all strategies, physicians in my sample were "likely" to treat patient emotion. This greater awareness for the role of emotion in medicine is also evident by the growing collection of research and writing being done by both social scientists as well as physicians (for a review see Chapter I). However, this shift in ideology may not guarantee a corresponding change in physician behavior. How a physician practices medicine is now likely to be shaped by agents beyond professional medicine (e.g. health care corporations, hospitals themselves, insurance companies), which frequently emphasize cost-effectiveness and efficiency (Cockerham 1995). Theses new forces could have remarkable affects on doctor-patient relationships, another viable area for future

research. Beyond these subject specific contributions, my work also made a few advances in the sociology of emotion.

Advancing The Sociology of Emotion

This dissertation developed sociological theory in several ways. First, I clarified and extended a few dimensions of the social constructionist theory on emotion management. Building upon the ideas of emotion work and emotion labor, I introduced two concepts that theoretically account for our efforts to manage the emotion of *other people*: emotion directing and emotion treatment. Although this was suggested in previous works (e.g. Thoits 1996), sociologists had yet to define and integrate these ideas into a broader model of emotion management.

Second, I proposed a definitive three-step model to explain physician treatment of patient emotion: patient triaging, emotion diagnosis, and strategy selection. The underlying forces for this process were two social elements: power and status. With power and status concepts I developed a sociological explanation, based predominately on Theodore Kemper's (1978, 1987, 1990) social relational theory of emotion, for physician treatment of patient emotions.

Combining these theories and their related concepts, I demonstrated the compatibility of two seeming incongruent perspectives: constructionism and structuralism. Both of these theoretical camps have unique strengths: constructionism's rich descriptive capabilities and structuralism's solid explanatory/predictive foundation. But, sociologists have yet to maximize the benefits of combining these two approaches. My research provided a perfunctory glimpse of just such a multi-theoretical approach,

albeit one of many steps necessary for augmenting collaboration between these theoretical camps. In addition to these theoretical contributions, my research made empirical advances for the sociology of emotion as well.

I reinforced the pertinence of the sociological perspective to studying emotions. As my dissertation demonstrated, Thoits's four-factor model of emotion and her corresponding typology of emotion management were excellent foundations to organize and define physician treatment strategies for patient emotion. The potential of Kemper's social relational theory was certainly suggested in this project, unfortunately it received marginal empirical support. His theory, although, offers one of the most parsimonious and generalizable explanations for emotion and its management, another useful foundation for future work.

This investigation produced theoretically generated empirical knowledge, which Smith-Lovin states (1995) is lacking in this area of sociology. It delivered empirical evidence for an objective inventory of physician treatment strategies to manage patient emotions. Findings, although inconclusive, did stimulate concerns about the possible effects of sex and race on the emotion management process.

As suggested throughout my discussion, there is a great deal of work within this area of sociological inquiry, spanning both micro and macro levels. On the micro level, identified strategies need to be applied and their effectiveness tested across patient populations, settings, as well as with different emotions. I conducted this research with the intent of applying emotion management to the "real world," a viable next step. For example, which strategies are effective with low literacy clients, families of pediatric

cancer victims, emergency rooms, hospital in-patients versus clinic out-patients, depressed or angry patients? More fundamentally, future research needs to confirm the reported use of emotion treatment strategies and probability to treat patient emotion by physicians in my sample, ideally through observational research. Are physicians actually using more counseling oriented strategies (e.g. explore, rationalize, and reassure) rather than prescribing psychotropic medications? As health care consumers become more empowered, to what extent does the role of negotiation impact a physician's selection of treatment strategies? I suspect findings from future qualitative research will have significant contributions to these and related questions.

On the macro level, researchers need to explore the effects of several trends in health care: the increasing number women in medicine, the growing business-orientation of medical practices, and the role of other social structure characteristics on this emotion management process. In particular, will emotions receive greater recognition in medical training and research, possibly producing a sub-speciality, medical emotionology? Outside of academic medicine, it is indeed questionable whether those managing (employing institutions) or reimbursing (insurance companies) physician services will allow them to treat such aspects of a patient's health, especially when more cost effective alternatives exist (e.g. clinical social workers, counselors, wellness educators). Which elicits another question, how do institutions influence emotion treatment content or process? If later research confirms sex or race effects on physician emotion treatment, how might this form of discrimination be corrected? And, if these two social characteristics influence this process, how might a person's social

class, ethnicity, financial/insurance status, or even one's diagnosis (e.g. AIDS, cancer, cirrhosis of the liver, hepatitis, mental illness) affect professional emotion treatment? Nonetheless, I believe that consumers will continue to demand medical care which appreciates the whole person, with emotion being a component of this holistic notion.

In conclusion, my dissertation research seems to have generated more questions than it answered. Nonetheless, it clarified theoretical insight into emotion management, produced some empirical information, and could spawn additional investigations into the professional treatment of our emotions.

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APPENDIX A:

SURVEY INSTRUMENT

DEALING WITH PATIENT EMOTIONS: INSTRUCTIONS

On the following page is a case involving a primary care patient with emotion complaints. After carefully reading the case, you will be asked first about the possible emotions this patient is experiencing and next about how you would *normally* respond to this person if they were a patient in your present practice.

Please rate the likelihood of *each* and *every* possibility. If you find an emotion or response to be virtually "guaranteed", in other words, "extremely likely," circle the number "**7**". If you consider another emotion or response "highly improbable," circle the number "**1**". If you consider a particular emotion or response "possible," please circle a number between "1" and "7" that roughly corresponds to your judgement of how likely that possibility is.

Be sure to rate all of the responses and, when finished, complete the information sheet at the end of this questionnaire. Please use the enclosed self-addressed stamped envelope to return the completed questionnaire.

Thank you for participating.

PATIENT CASE

Patient is a 42 year old married white male treated over the past year for new onset of Type-II Diabetes Mellitus. The patient successfully completed diabetes education classes several months ago, demonstrated adequate knowledge and self-care skills, and has since effectively controlled his blood glucose levels by diet only. Patient was last seen one month ago for a routine follow-up exam, which showed the patient to be in excellent health, however the patient reported "still feeling quite upset about having Diabetes". He has returned on this date with repeated concerns for his "excessive moodiness", continuing to exhibit a great deal of emotion about having Diabetes. Other medical factors have been ruled out.

PATIENT EMOTIONS

Having read the above patient case, evaluate the likelihood for this patient experiencing each of the following emotions. Review each emotion carefully and circle one number (1 = *very unlikely* to 7 = *very likely*) for *each* and *every* possible emotion response for this particular patient.

1. Anger

Very Unlikely						Very Likely
1	2	3	4	5	6	7

2. Anxiety

Very Unlikely						Very Likely
1	2	3	4	5	6	7

3. Fear

Very Unlikely						Very Likely
1	2	3	4	5	6	7

4. Sadness/depression (minor, not clinical depression)

Very Unlikely						Very Likely
1	2	3	4	5	6	7

5. Satisfaction/contentment

Very Unlikely						Very Likely
1	2	3	4	5	6	7

RATING POSSIBLE RESPONSES

Read each response carefully and circle one number (1= very *unlikely* to 7 = *very likely*) for *each and every* response, thus indicating the probability of your using each technique.

1 2 3 4 5 6 7	A) Schedule a follow-up appointment in a month to reassess how the patient is feeling.
1 2 3 4 5 6 7	B) Ask the patient if he had any other questions and end the consultation.
1 2 3 4 5 6 7	C) Offer the patient a referral to a mental health professional for support or assistance.
1 2 3 4 5 6 7	D) Advise the patient to get away for awhile, take a vacation literally or figuratively from whatever is bothering him.
1 2 3 4 5 6 7	E) Suggest he watch a good movie/television program, read a good book, or do something enjoyable and fun to help to get a break from things for awhile.
1 2 3 4 5 6 7	F) Reassure the patient, stating for example, "You're doing very well and the likelihood of complications is reduced by taking care of yourself."
1 2 3 4 5 6 7	G) Help the patient identify and concentrate on the positive aspects of their situation.
1 2 3 4 5 6 7	H) Express empathy (feeling with the patient) possibly stating, "I've felt that way at times too and probably would feel scared too in the same situation."
1 2 3 4 5 6 7	I) Aid the patient in accepting the situation, whatever it might be, stating for example, "You're not alone, a lot of people have faced similar problems and have done quite well."
1 2 3 4 5 6 7	J) Explore with the patient what frightens them the most.
1 2 3 4 5 6 7	K) Express sympathy (feeling for the patient), possibly stating, "Oh, I'm sorry you're Feeling scared, but keep in mind we are partners in this and I'm here to help you through it."
1 2 3 4 5 6 7	L) Encourage him to begin an appropriate exercise program to help them feel better and relieve some of the emotional strain.
1 2 3 4 5 6 7	M) Recommend/prescribe a mild anti-anxiety medication for a brief period to help the patient.
1 2 3 4 5 6 7	N) Suggest the patient learn some basic relaxation techniques, possibly teaching them yourself or referring him to a community resource for instruction.
1 2 3 4 5 6 7	O) Suggest the patient "treat themselves," such as an occasional special meal or snack.
1 2 3 4 5 6 7	P) Make a light joke or remind him that sometimes "laughter is the best medicine" and advise them to seek out humor (movie, television program, book, comedian, etc...).
1 2 3 4 5 6 7	Q) Encourage the patient to focus attention and energies on improving their health, making positive life changes.
1 2 3 4 5 6 7	R) Talk about these feelings and encourage the patient to ventilate (express) these emotions.
1 2 3 4 5 6 7	S) Ask the patient to visualize/imagine themselves being at peace and/or expressing this emotion.
1 2 3 4 5 6 7	T) Help him separate the physical feelings from emotional feelings and discuss how we can sometime misinterpret one for the other.
1 2 3 4 5 6 7	U) Assist the patient in re-defining the situation, stating "You could look at this situation like this..."
1 2 3 4 5 6 7	V) Concentrate only on the medical problem(s) at hand and avoid being distracted or drawn into the psychiatric aspects of this patient's care, possibly reminding the patient that you're trained to assist them with medical issues.

DEMOGRAPHIC INFORMATION

Today's date: _____

Name (optional): _____

Age: _____ Sex: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single, never married

Race: ❑ White, non-Hispanic ❑ African-American ❑ Asian-American ❑ Hispanic ❑ Native-American ❑ Other: _____

Medical school attended: _____

Year of graduation: _____

Type of residency (if any): ❑ Family practice ❑ Internal medicine ❑ Other: _____

Facility & location of residency: _____

Other advanced training: _____

Years of practice (post-residency): _____

Current practice: ❑ HMO ❑ Solo private practice ❑ Group private practice ❑ Hospital owned practice ❑ Faculty - teaching institution ❑ Government facility (e.g. VA, military clinic) ❑ Other: _____

Employment: ❑ Salaried ❑ Self-employed ❑ Other: _____

Average number of *out-patients* seen daily: _____

Average amount of time spent per *out-patient* visit: _____

Average number of *in-patients* seen daily: _____

Average amount of time spent per *in-patient* visit: _____

Comments or suggestions: _____

_____

_____

_____

APPENDIX B:

INITIAL INTRODUCTION LETTER

SCHOOL OF
MEDICINE IN NEW ORLEANS
Louisiana State University
Medical Center
Earl K. Long Medical Center
5825 Airline Highway
Baton Rouge, LA 70805-2498
Telephone: (504) 358-1383

Family Medicine

Dr. *FIRST NAME * LAST NAME*
ADDRESS
CITY, STATE * ZIP CODE*

February 26, 1998

Dear Dr. *LAST NAME*,

I am assisting a doctoral candidate at L.S.U., Vaughn DeCoster, on his dissertation research and would like to solicit your participation. This study explores how primary care physicians deal with patient emotion during clinic consultations. Most of the existing work in this area is theoretical and lacks direct input from practicing physicians similar to that which we are collecting. Notably, findings from Mr. DeCoster's first phase of this project have been accepted for publication.

As one of a small sample of physicians selected, your involvement is quite crucial; all we ask is that you complete a brief questionnaire. All information will be held in strict confidence, with anonymity guaranteed. You will receive the research packet within the next ten days.

We would greatly appreciate your participation in this research. If you have any questions or need additional information please do not hesitate to contact the principal investigator.

Warmest regards,

John T. Howe, M.D. Dissertation Committee, Member	F. Andrew Deseran, Ph.D. Dissertation Committee, Chair	Vaughn A. DeCoster, A.B.D. Principal Investigator Baton Rouge: (504) 768-1704

APPENDIX C:

FIRST COVER LETTER AND INFORMED CONSENT FORM

SCHOOL OF
MEDICINE IN NEW ORLEANS
Louisiana State University
Medical Center
Earl K. Long Medical Center
5825 Airline Highway
Baton Rouge, LA 70805-2498
Telephone: (504) 358-1383

Family Medicine

Dr. *FIRST NAME * LAST NAME*
ADDRESS
ADDRESS
CITY, STATE * ZIP CODE*

April 22, 1997

Dear Dr. *LAST NAME*,

As discussed in a letter you received from Dr. John Howe, I am a doctoral candidate researching how physicians deal with patient emotion during clinic consultations. This is the second and last phase of my dissertation research project.

I have enclosed a consent form, the survey instrument, and a self-addressed stamped envelope to return the completed packet. Time required is approximately ten minutes. First, read the consent form and sign, if you are willing to participate, then simply follow the instructions on the survey. Please complete the entire packet and return by **May 15**.

Your involvement is an integral part of my project. Hence, I am on twenty-four hour call to answer questions or assist you in completing the survey. You may reach me by calling my digital pager here in Baton Rouge: **(504) 327-8486**.

Sincerely,

Vaughn A. DeCoster, A.B.D.
Principal Investigator
Office: (504) 768-1704

INFORMED CONSENT FORM

TITLE: PHYSICIANS DEALING WITH PATIENT EMOTIONS

INVESTIGATORS: VAUGHN A. DeCOSTER,
UNDER THE SUPERVISION OF DR. FORREST A. DESERAN

Department of Sociology
Louisiana State University
Baton Rouge, LA
(504) 388-1645

DESCRIPTION: The present study is interested in how physicians deal with patient emotions. This study will involve one session lasting perhaps as long as twenty minutes. As a participate in this study you will be asked to complete a short questionnaire.

RISK AND BENEFITS: The benefits of participating include the satisfaction of contributing to research about emotions in social interactions. There are no risk involved from the participation in this study.

VOLUNTARY PARTICIPATION: Your participation in this research is completely voluntary. There are no payments.

CONFIDENTIALITY: The questionnaire is distributed randomly with no record of your name kept with or on the questionnaire. All information will be held in the strictest of confidence.

RIGHT TO WITHDRAW: You are free to refuse to participate in this study or to withdraw from this study at any time. Your decision to withdraw will bring no negative consequences, no penalty to you.

INFORMED CONSENT: I have read the description, including the nature and purpose of the study, the procedures to be used, the potential risk and side effects, as well as the option to withdraw from the study at any time. Each of these items have been explained to me by the investigator. The investigator has answered all of my questions regarding the study, and I believe I understand what is involved. My signature below indicates that I freely agree to participate in this experimental study and that I have received a copy of this agreement from the experimenter.

_____ _____

Signature Date

APPENDIX D:

FOLLOW-UP POSTCARD

May 22, 1997

Dear Physician:

Several weeks ago we sent you a questionnaire about how physicians deal with patient emotion during clinic consultations. If you have already completed and returned it to us please accept our sincere thanks. We really appreciate your time and thoughts. If you have not yet responded, please do so today. It is extremely important that your responses be included in the study.

If by some chance you didn't receive the questionnaire and self-addressed stamped envelope or they got misplaced, please call Vaughn DeCoster right now at his office **768-1704** (Baton Rouge) or via digital pager **327-8486** (Baton Rouge) and he will get another in the mail to you today.

Warmest regards,

John T. Howe, M.D. Dissertation Committee, Member	F. Andrew Deseran, Ph.D. Dissertation Committee, Chair	Vaughn A. DeCoster, A.B.D. Principal Investigator

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APPENDIX E:

SECOND COVER LETTER

SCHOOL OF
MEDICINE IN NEW ORLEANS
Louisiana State University
Medical Center
Earl K. Long Medical Center
5825 Airline Highway
Baton Rouge, LA 70805-2498
Telephone: (504) 358-1383

Family Medicine

Dr. *FIRST NAME * LAST NAME*
ADDRESS
CITY, STATE * ZIP CODE*

June 11, 1997

Dear Physician:

As discussed in a letter you received from Dr. John Howe, I am a doctoral candidate researching how physicians deal with patient emotion during clinic consultations. Several weeks ago we sent you a questionnaire about how physicians deal with patient emotion during clinic consultations. If you have already completed and returned it to us please accept our sincere thanks. If you have not yet responded, please do so today. Because you are one of a small sample of physicians selected, it is extremely important that your responses also be included in the study if the results are to accurately represent practicing physicians.

I have enclosed an additional copy of the survey questionnaire and a self-addressed stamped envelope for those of you that did not receive a research packet.

Your involvement is an integral part of my project. Hence, I am on twenty-four hour call to answer questions or assist you in completing the survey. You may reach me by calling my digital pager here in Baton Rouge: **(504) 327-8486**.

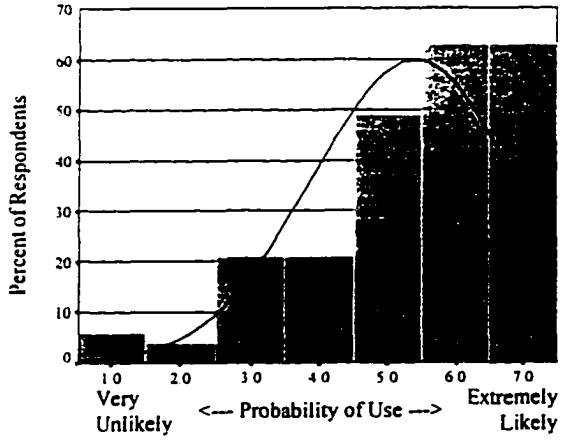
Sincerely,

Vaughn A. DeCoster, A.B.D.
Principal Investigator

APPENDIX F:

HISTOGRAMS OF RESPONSES TO PATIENT EMOTION TREATMENT STRATEGIES

Accept



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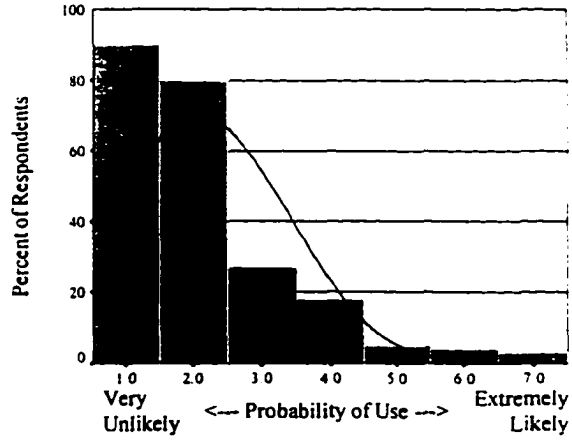
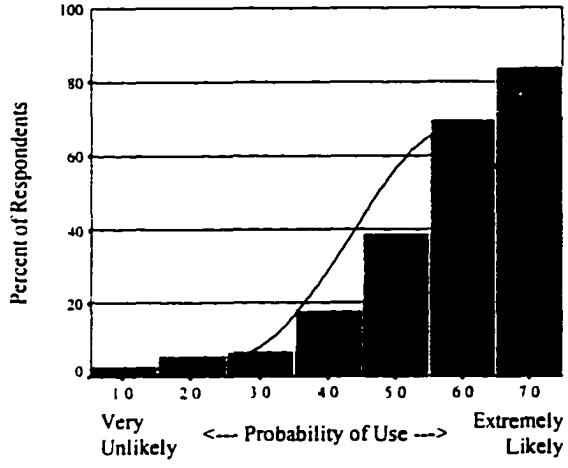


Catharsis



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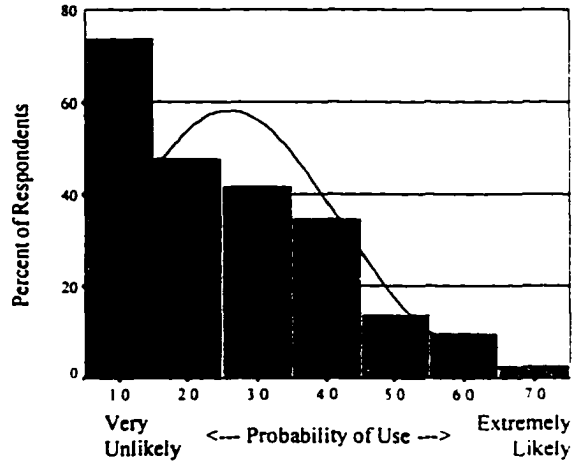
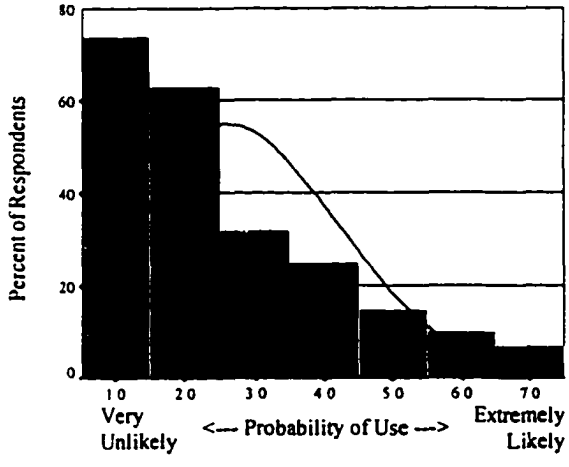


Eat



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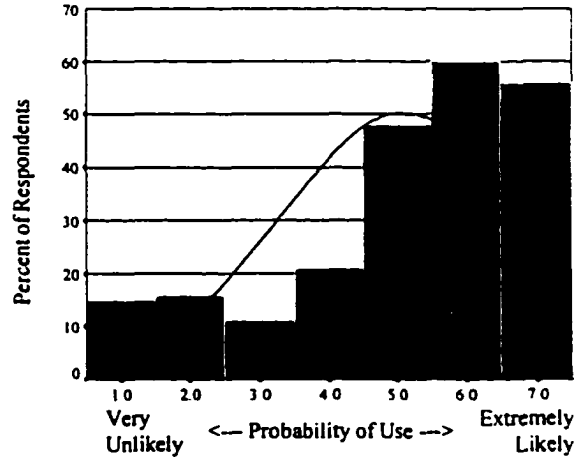

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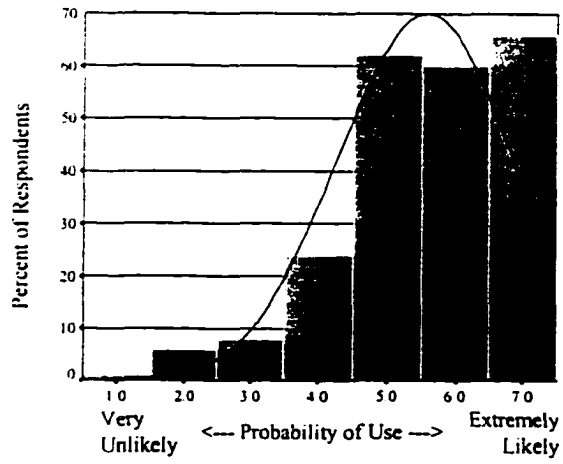

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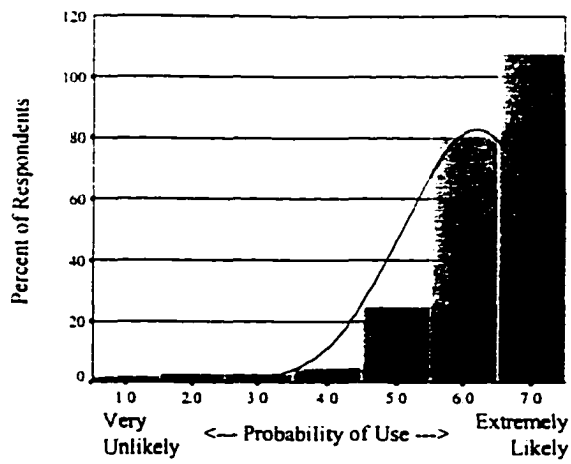

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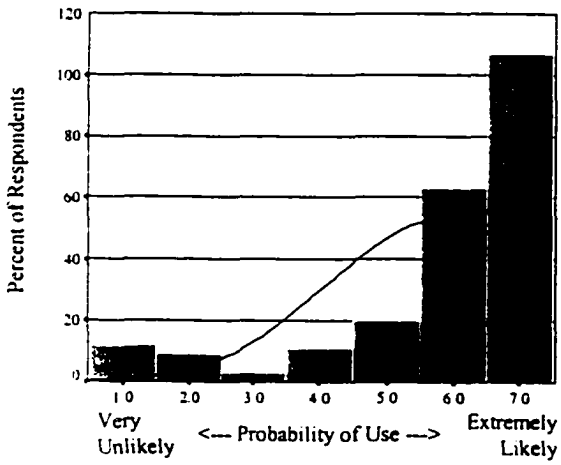

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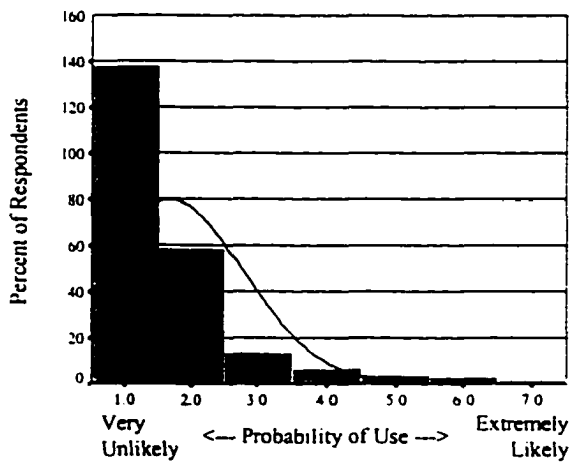

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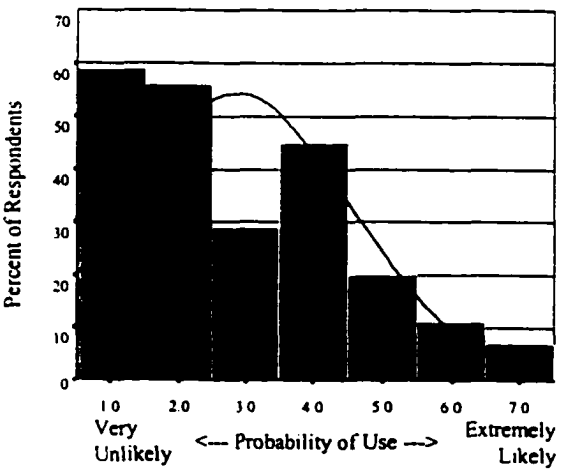

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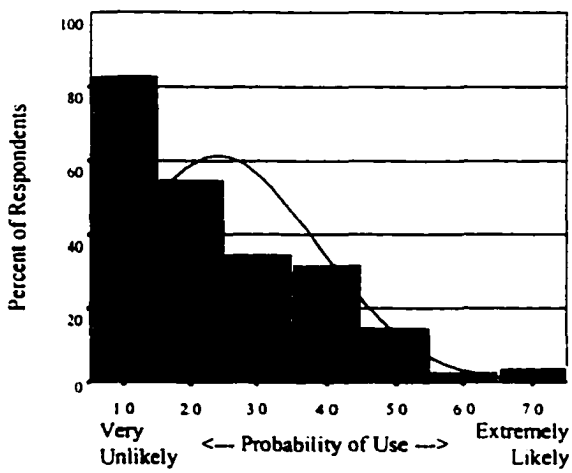

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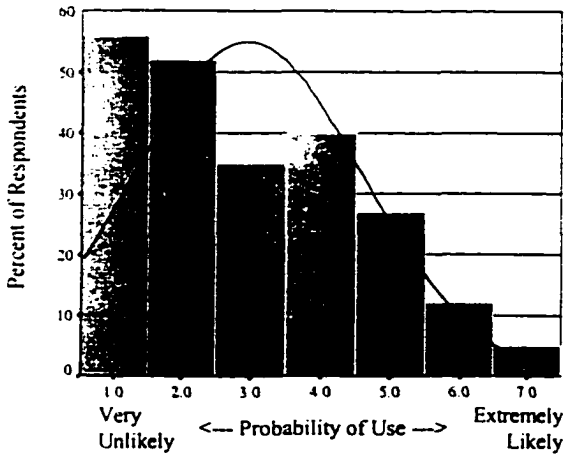

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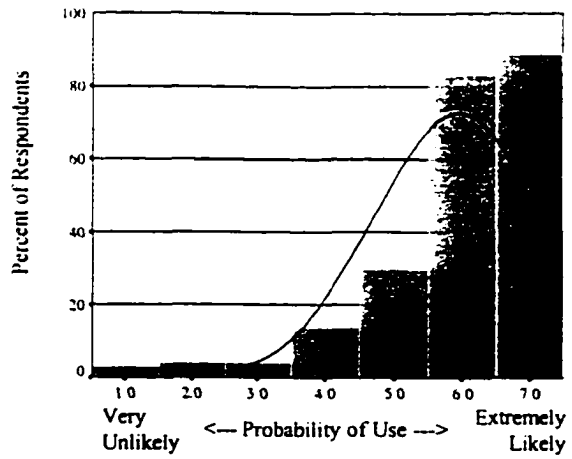

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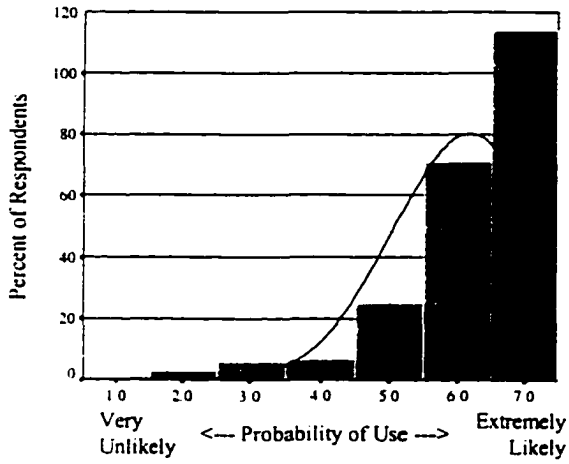

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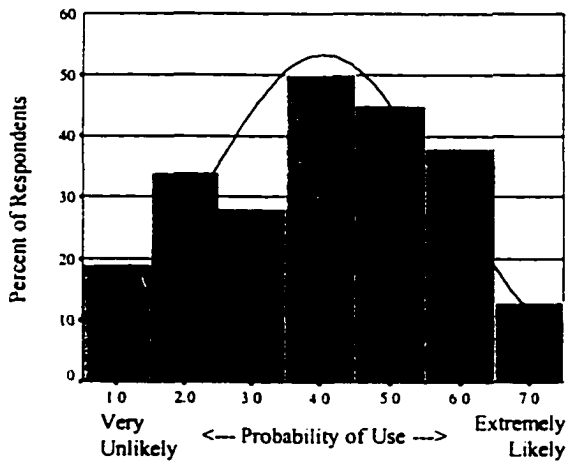

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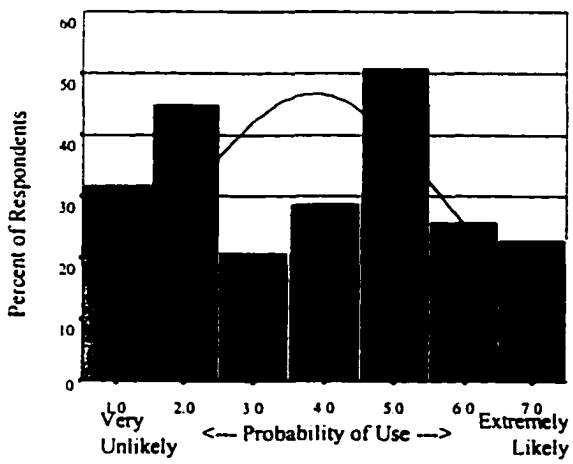

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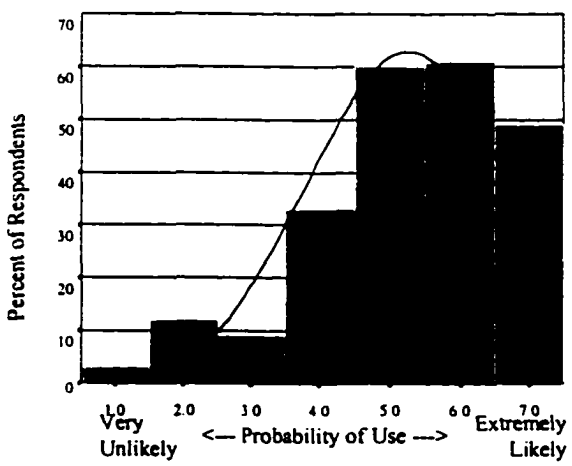

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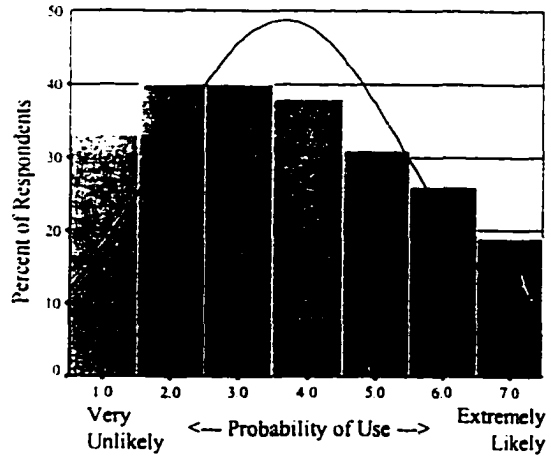
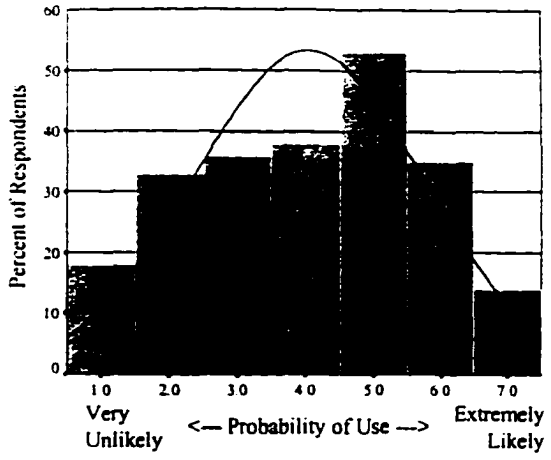
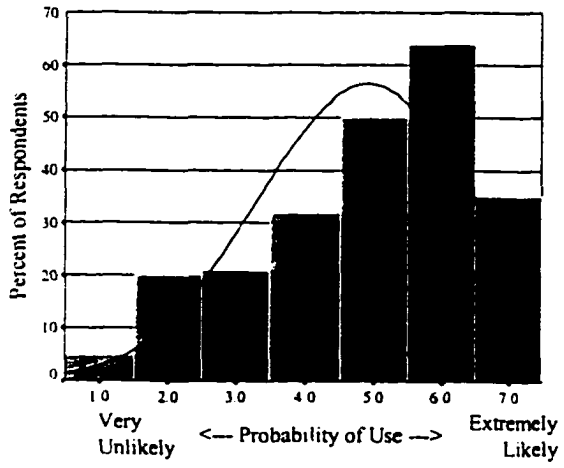


Relaxation



Sympathize



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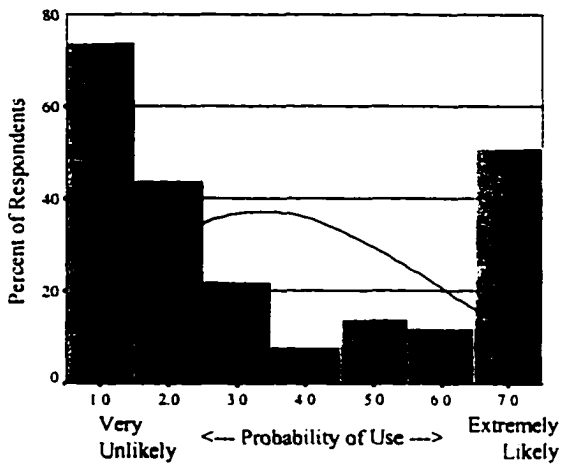


VITA

Vaughn A. DeCoster was born in Inglewood, California, spent his early childhood in Simi Valley, California, but the majority of his upbringing occurred in the rural Northwest Arkansas community of Aurbuckle Island. He received a Bachelor of Art degree (cum laude) in psychology from the University of Arkansas, Fayetteville. Vaughn then attended Tulane University and earned a Master of Social Work degree, specializing in direct practice.

Practicing as a medical social worker for several years in the Greater New Orleans area for Tenet Health Care and Tulane University Medical Centers before beginning doctoral work at Louisiana State University, Vaughn brought a deep appreciation for the role of emotion in acute care settings. His clinical work with Diabetes patients at the Baton Rouge General Diabetes Center also contributed to his interest in emotion and health. At present, he is an Assistant Professor of Sociology and Humanities at Our Lady of the Lake College in Baton Rouge and maintains a small private practice, specializing in assisting people with medically related issues and stress management.

Vaughn is married to Marla Gordon DeCoster, also a clinical social worker. Both are avid scuba divers and currently reside in Baton Rouge.

DOCTORAL EXAMINATION AND DISSERTATION REPORT

Candidate: Vaughn A. DeCoster

Major Field: Sociology

Title of Dissertation: The Effects of Gender and Race on Physician Treatment of Patient Emotion

Approved:

Major Professor and Chairman

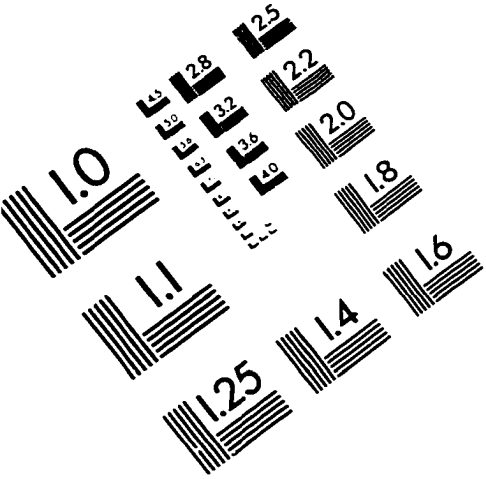
Dean of the Graduate School

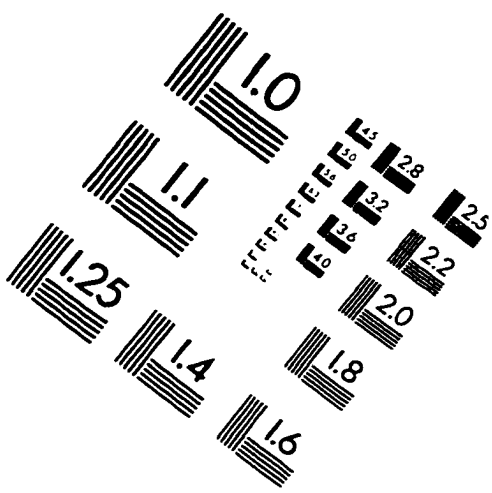
EXAMINING COMMITTEE:

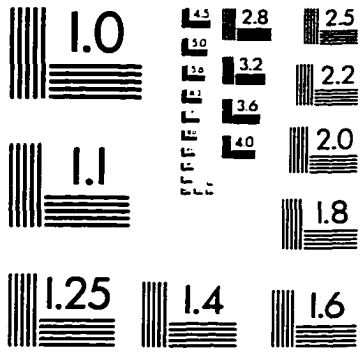
Date of Examination:

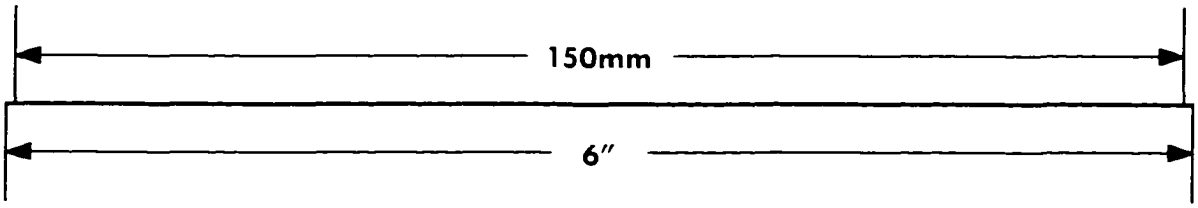
February 11, 1998

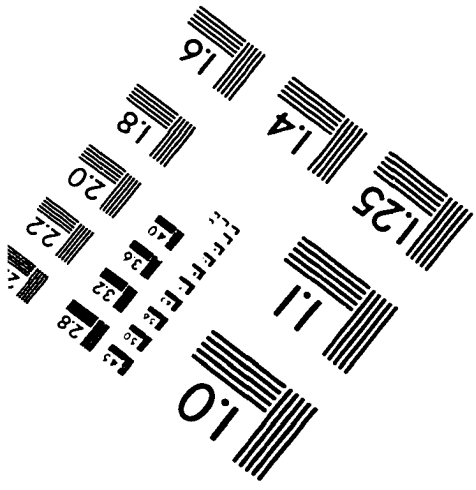
IMAGE EVALUATION
TEST TARGET (QA-3)

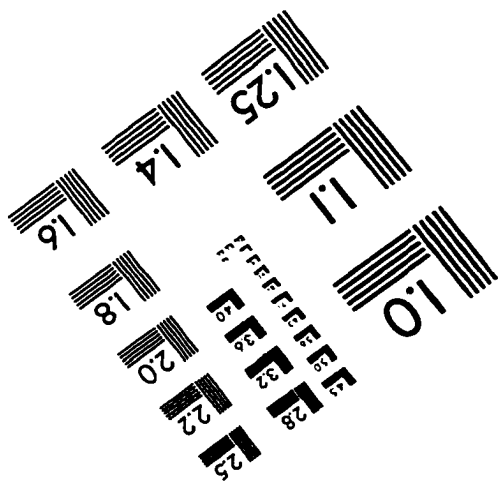












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